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Medical and Chirurgical Faculty of the State of Maryland

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Maryland
STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 1 | *January, 1952* | NUMBER 1

FOREWORD

GEORGE H. YEAGER, M.D.

Secretary and Editor

The advent of this publication represents the culmination of the hopes and efforts of the officer body of the Faculty. At the same time, it marks the demise of the Bulletin and the incorporation of the News Letter.

Scientific articles will be published in as concise a style as possible. Should greater length and detail be desired, access should be made to reprints and the original manuscript.

Circulation figures do not of necessity indicate reader interest. If our State Journal is read throughout, a worthwhile service will have been rendered. The argument has been advanced that it will be difficult to obtain articles for a journal of this size. It is our belief that articles published in a journal for State distribution represents more effective reader interest than journals of larger circulation.

We are fully persuaded that the best interests of the Faculty demand some means of binding individual members more closely to the organization. It is imperative that the work of the State Society, as well as that of the American Medical Association, be kept before the members.

The facilities of the excellent library of the Faculty, to a very large percentage of our membership, are not available because of geographical factors. Other inducements, as well as some direct means of communication, should be offered. Experience has taught other States that the strongest influence for good in these directions has been a State medical journal, owned and controlled by the State Society, managed solely in the interest of its members, and sent to each of them regularly without cost beyond their annual dues.

Issuance of a journal at this time represents re-vitalization of an old custom of the Medical and Chirurgical Faculty. The venture is neither a "new idea," nor a "new departure."

From October 1839 to June 1843 the Faculty published the "Maryland Medical and Surgical Journal and Official Organ of the Medical Department of the Army and Navy of the United States." From May 1887 to March 1918 a publication known as the "Maryland Medical Journal" (Vol. 1, 61, #3) carried the notes and communications of the Faculty. For a brief period (1905–1908) this Journal became the official publication medium of the Faculty and included the transactions. In 1908 The House of Delegates of the Faculty terminated its contract with the Maryland Medical Journal for publication of the transactions and initiated an official monthly Bulletin, which was discontinued in 1922. This contained scientific articles,

transactions and local items of interest, and was quite different from the small 4 to 8 page Bulletin, which has been published since 1927 to date.

Many objections have been raised to the re-establishment of a Journal. Certainly it represents an increased burden for the office staff. If you want a Journal, issued by your State Society, lend your support. Read it! Criticize it! Help make it worthwhile! If your are willing to include it as essential reading to your professional way of life, then it must succeed.

Add it to your hedonistic as well as your professional pursuits. The probability of the *Maryland State Medical Journal* becoming a fixed asset of the Medical and Chirurgical Faculty of Maryland will thereby be enhanced.

A SUGGESTION FROM THE EDITOR

The Editor requests that the members of the Medical and Chirurgical Faculty submit for publication items of interest to the profession, case reports and scientific papers. It's your JOURNAL; make it a success by contributing.

Officers' Corner

THE ACTIVITIES OF THE MEDICAL AND CHIRURGICAL FACULTY

WALTER D. WISE, M.D.

President, 1951

For a long time, it has been evident to officers of the Medical and Chirurgical Faculty that many members have inadequate knowledge of the activities of this Society and its indirect value to them. Some members feel that because they do not use the Library, for reasons of distance, lack of time or some other cause, they get no benefits beyond the pleasure and advantages of the medical meetings, which in most state societies are limited in number, (this function being for the most part the responsibility of the city and county components). Because it seems necessary that the manifold activities of our State Society and its components become better known, it was decided to find a more fitting medium for the transmission of their transactions. To this end, as is pointed out elsewhere in this issue by Dr. Edwards, Chairman of the Council, it was decided to publish a JOURNAL. It is almost certain that at no time in our history has it been more important to have a well organized and supported state medical organization.

The number of doctors in our Society has increased from 1232 in 1925 to 2401 in December 1951, and the activities of our organization have multiplied to a very great degree.

In 1925 there were the same three committees, as we have today, which are elected by the House of Delegates: The Committee on Scientific Work and Arrangements, the Library Committee and the Finney Fund Committee. The Professional Conduct Committee, which was inaugurated in April 1950, is the only other committee included in the Constitution and By-Laws.

The work that may be called routine, such as that of the Library, which has about doubled in the past 25 years, the regular medical meetings, the Council meetings and those of the Standing Committees, has gone on as before except for a considerable increase in the volume of work and the results. At present there are 32 appointed committees, of which 6 were in existence in 1925, at which time there were only 8 committees all told.

In addition to the duties of the regular standing committees, some of the newer matters that have called for varying numbers of meetings and hours of work and which have resulted, in some cases, in the appointment of additional Standing Committees, are:

a. Our part in developing the Blue Cross, on whose Board (Maryland Hospital Service) we have 24 corporate members.
b. Our part in the development of the Blue Shield, on whose Board (Maryland Medical Service) we have 8 Class "A" members.
c. The development of the Medical Care Plan. (As a result of a recommendation of the House of Delegates of the Medical and Chirurgical Faculty.)
d. A detailed survey of the Hospitals of Maryland under direction of the Medical Committee of the State Planning Commission.
e. Aid in the implementation of the Hill-Burton Act, of which funds there has been spent in Maryland in the past four years $4,177,000 of Federal money. By June 1952 the amount will be $5,197,836.06. There has been participation in twenty-five projects, with a total expenditure at the end of the current year of over $17,000,000. This has been done through a state-wide committee of laymen and representatives of the State Department of Health and the Medical and Chirurgical Faculty.

f. The Faculty has representatives on the Red Cross Regional Blood Center Blood Program Committee and Medical Committee.

The representatives of the Faculty on the above mentioned Boards, Committees, etc. conduct their activities independent of the Faculty office. The Chairmen of the 32 existing Committees carry on the functions of their Committees usually through the office of the Faculty.

The Committees which functioned in 1925 and are still in existence are as follows:

1. Maternal and Child Welfare Committee, which has been very active and helpful in reducing the mortality rate in newborn babies and young children.
2. Memoir Committee.
3. Eugene Fauntleroy Cordell Fund Committee. (Formerly Fund for Widows and Orphans, and given present name to honor Dr. Cordell.)
4. Committee on Public Instruction. Radio and television programs are given under the auspices of the Medical and Chirurgical Faculty and Baltimore City Health Department, and other public educational programs through State and City Health Departments.
5. Committee on Defense of Medical Research. A most recent activity was the fine work in the Antivivisection fight in Baltimore City, and resulted in the formation of the Maryland Society for Medical Research—a strong organization deserving of warm support.
6. Legislative Committee. There has always been a Legislative Committee and the work carried on by these members, particularly during the time when the General Assembly meets in Annapolis which is now every year, is a very heavy load. Members of this Committee, particularly the Chairman, are compelled to spend much time at Annapolis to attend meetings of the Legislature so as to bring to the attention of the members of the House and Senate the effect on the public of Bills pertaining to medicine and related matters. The Committee makes every effort to protect the health and welfare of the citizens of Maryland.

Since 1925 the following Committees, besides others which have been discharged, have been appointed and in most instances the name indicates the work of the Committee:

1. Committee on Constitution and By-Laws. The Faculty now has a standing Committee on Constitution and By-Laws and in these changing times this Committee spends a great deal of effort in keeping the Constitution current.
2. Physiotherapy Committee.
3. Army Medical Library Committee.
4. Cancer Committee.
5. Tuberculosis Committee.
6. Mental Hygiene Committee.
7. Committee on Rural Medicine. This Committee has held in recent years two Rural Health Conferences in the Faculty Building, which were attended by physicians and lay people from throughout the State.
8. Committee on Industrial Health.
9. Blood Bank Advisory Committee.
10. Medical Care Campaign Committee. The Council at its meeting on February 10, 1949 adopted the recommendation of a Special Committee and authorized the formation of this Committee, which has representatives from every County in the State, as well as a Speakers Bureau. This Committee disseminates educational information to the public, provides speakers, and carries on an active campaign against Federalized medicine.
11. Sesquicentennial Committee (New Building). Subcommittees:
    Finance.
    Building Plans.
12. Committee to Advise the State Industrial Accident Commission.
13. Committee on Medical Service and Public Relations.
14. Postgraduate Educational Committee.
15. Diabetic Detection Committee.
16. Committee to Study Certain Phases of Medical Economics.
17. Committee to Consider the Relationship Between Hospitals and Specialties and the Manner of Payment for Professional Services.
18. Presidential Advisory Committee.
19. Civilian Defense Committee with its several subcommittees.

Some of the recently appointed Committees are functioning as follows:

20. A Scientific Speakers Bureau has made available to the Component Medical Societies a list of physicians, who will address their societies on current medical subjects.

21. Advisory Committee to the Woman's Auxiliary, which consists of five Faculty members who are available at all times to assist and advise the officers of the Auxiliary in their projects.
22. The Advisory Committee to the State Health Department, which meets with members of the State Health Department to iron out any difficulties which may arise between the profession and State Department of Health. This is an active Committee and an able detailed report was given by Dr. A. A. Pearre at the Ocean City Semiannual Meeting, September 14, 1951.
23. Professional Conduct Committee. Never a week goes by that this Committee does not receive mail from either lay people or doctors embodying complaints. This Committee gives a great deal of study to the problem and settles the differences in many cases.
24. The Committee for the Study of Pelvic Cancer was approved by the House of Delegates and Council in April 1951 and has set up an office in the Faculty building under the auspices of the American Cancer Society.
25. In recent months a Joint Committee of the Faculty and Bar Association has been formed and it is hoped through their efforts to have a closer liaison between the Medical and Legal professions. To this end they are holding symposiums on timely subjects to which the medical and legal professions, as well as the public, are invited. One important meeting on the Narcotic Problem has been held. In December there will be a meeting on Court Procedures.

The amount of time and thought put into the efforts of these committees and the amount of material reported out, would surprise anyone not familiar with the proceedings. Perhaps the unknowing visualize the Committees as having a meeting or two and finishing their work. This is true in a few instances. Those who were responsible for developing the Blue Shield, the Medical Care Plan for the Indigent, those who worked on the "dog fight" or made the hospital survey for the obtaining of the Hill-Burton Act funds, would have a different account to relate.

The amount of material that comes to 1211 Cathedral Street from the Chicago and Washington offices of the American Medical Association, and almost countless independent groups of doctors and lay organizations, largely concerning matters detrimental to the profession or public welfare would likewise be surprising. This has to be read and acted upon. As stated, the Maryland Legislature now meets yearly instead of every two years as formerly and this means that the Legislative Committee and Director of the Faculty have to give almost twice as much time as formerly to the guarding of the public interest.

Probably few of our members know that under the Law the Governor of Maryland requests the officials of the Medical and Chirurgical Faculty to submit lists of names, from which he makes appointments on the following Boards:

1. Medical Board for Occupational Disease for the State Industrial Accident Commission.
2. Council on Medical Care of State Department of Health.
3. Advisory Council on Hospital Construction to the State Board of Health.
4. Advisory Board to the State Department of Health for Licensing of Hospitals.
5. State School Health Council.
6. State Board of Physical Therapy Examiners.

The first Annual Meeting of the Woman's Auxiliary of the Medical and Chirurgical Faculty was held in April 1950 and this organization is taking an active part in community affairs, educational projects, etc., and the Faculty office is doing the secretarial and clerical work of the Auxiliary.

One outstanding function of our State Society that should be cherished and forever protected is the election of the State Board of Medical Examiners. As far as we know, we are the only State having this privilege.

These are some of the many activities to which the members of the Medical and Chirurgical Faculty give their time, advice and knowledge to help the citizens of the State of Maryland. Many of you are on some of these committees, some have wide knowledge of the activities of the Society as a whole—many do not. To acquaint the entire membership with our state-wide activities is one of the chief reasons for the desire to publish a larger Journal.

For the most part, the subjects just mentioned are at the state level. About one-half of the State Society membership is in Baltimore City. The Baltimore City Medical Society uses the Faculty head-

quarters and office staff. Their Society is broken up into numerous sections, with their many meetings which have to be arranged. They have their own committees as follows:

1. Committee on Geriatrics.
2. Committee on Emergency Medical Calls.
3. Health and Physical Education.
4. Hospital Survey Committee.
5. Legislative Committee.
6. Maternal Mortality Committee.
7. Maryland Committee Against Un-American Activities.
8. Program Committee.
9. Committee on Public Medical Education.
10. Magistrate's Committee.
11. Membership Committee.

The City Society also has its own Woman's Auxiliary. The activities of the Baltimore City Medical Society plus those of the County Societies, of course, are to be added to the total accomplishment of the State Society.

The Bulletin of the Medical and Chirurgical Faculty, a leaflet, was inaugurated in December 1927 to give the members a concise account of the activities of the State Association. Subsequently, in April, 1949, the Secretary, Dr. Yeager, felt that it would be advisable to supplement the Bulletin with a News Letter, which would be informal and carry information to the members relative to the activities of the Medical and Chirurgical Faculty, American Medical Association, etc. The Journal will bring the information contained in the Bulletin and News Letter, plus scientific articles and editorials. We hope it will be extremely valuable.

One sometimes hears the inquiry—what do I get out of the State Society for my dues? We hope the reading of this Journal will give a clear answer. One answer that has been true over the years is—you have working for your interest and in the interest of the public, several hundred committeemen who give a surprising amount of time and energy. Their services could not be purchased with money.

It is hoped that in forthcoming issues of the Journal, the members will become familiar with the activities and accomplishments of the Medical and Chirurgical Faculty.

A MESSAGE FROM THE TREASURER

J. ALBERT CHATARD, M.D.

Another milestone has been reached by the Faculty. Last year as your Treasurer I advised an increase of dues. Such a recommendation had become necessary because of the continued rising cost of upkeep. With the recommendation there was included the hope that a Journal would be published, and that it would serve as a medium of cementing our relations throughout the State. This hope now sees its fruition with the issuance of *The Maryland State Medical Journal*, as the official publication of the Medical and Chirurgical Faculty.

I know the Editorial Board intends to utilize the Journal as a means of reaching our membership with news, reports, and programs of our Component Societies, as well as timely and interesting addresses and scientific papers.

It is planned to print the Transactions in the Journal. The presidential address, reports of the committees and House of Delegates, and the scientific papers, as presented during the Annual Meeting, will be published as soon as feasible after the April 1952 meeting.

Please don't look on this as another medical journal in an already crowded field. Think of it as your home paper, with news you want to hear. Your Officers have neither time nor means to talk to each member in person. The work of the office cannot be appreciated or known except through the medium of a Journal.

If it proves to be a worthy publication, please give it your heartfelt support and praise. Criticism is requested, and suggestions for improvement eagerly sought.

Ultimate good can be accomplished if each member will take pride in his Association, THE FACULTY, and support its efforts.

A STATEMENT BY THE CHAIRMAN OF THE COUNCIL

C. REID EDWARDS, M.D.

With the issuance of *The Maryland State Medical Journal*, the Medical and Chirurgical Faculty moves forward. Thereby it hopes to transform the Bulletin which has served a good, though inadequate, purpose into a Journal which will lend itself to a planned expansion and serve the medical profession of the State of Maryland in a way that has not been possible in the past.

The importance of a thoroughly organized, alert State Society has never been so evident as at present. It is imperative that every physician in the State be acquainted with the duties, responsibilities and potentialities of the Medical and Chirurgical Faculty. The Journal should serve as a medium of conveying necessary information to everyone. While the details of administrative duties must be attended by its elected officers and numerous appointed committees, every member of the Faculty should know what is required of the Faculty and what is being done. It now will be possible to keep every one informed and thereby to consolidate the efforts of the Faculty and to make it the living, forceful organization it should be.

Temporarily the responsibility of editing this Journal is the duty of the Secretary. A committee is working on a permanent plan for its editing. The result should be a publication equal, if not superior to other State Medical Journals.

Your coöperation in the support of this Journal is solicited.

ANNUAL MEETING DATES

Tuesday and Wednesday, April 29 and 30, 1952

Due to a conflict of dates with National Associations, the Council of the Medical and Chirurgical Faculty has authorized the Chairman of the Committee on Scientific Work and Arrangements, Dr. Beverley C. Compton, to change the date of the Annual Meeting to Tuesday and Wednesday, April 29 and 30, 1952. The House of Delegates will meet on Monday, April 28, 1952. To date Dr. Cornelius P. Rhoads of New York has been obtained as one of the principal speakers. He will address the meeting on Tuesday evening, April 29, 1952 on "Recent Develments in Cancer Research."

Reports

THE MARYLAND ADVISORY COMMITTEE TO SELECTIVE SERVICE—A REPORT

DR. R. WALTER GRAHAM, JR.
Chairman

On October 7, 1950, the Maryland Advisory Committee on the Selection of Physicians, Dentists, and Allied Specialists was appointed by Dr. Howard Rusk, Chairman of the National Advisory Committee. Dr. Rusk's authority for such action was established by Public Law 779 and by order of the President of the United States. Those named by Dr. Rusk were: R. Walter Graham, Jr., M.D., Chairman, Robert H. Riley, M.D., and Harry B. McCarthy, D.D.S. The order of appointment stated that "the Chairman may appoint such additional members to the Committee as may be necessary to carry out its functions. Your Committee shall appoint such volunteer advisory subcommittees to serve at local levels as may be necessary; e.g., separate committees of doctors, dentists and veterinarians to give appropriate consideration to the respective needs of the armed forces and of the civilian population for the services of the members of their respective professions." The order of appointment further stated that "the responsibilities of your committee are (1) to establish and maintain liaison with your State Director of Selective Service, (2) to advise the Selective Service System concerning the classification of individual members of these health professions who are subject to classification by the Selective Service Boards, (3) to be responsible for carrying out within the State policies established by the National Advisory Committee."

To the original members of the Committee, the following have been added: Whitmer B. Firor, M.D., Arthur L. Brueckner, D.V.S., Mrs. Angela Shipley, R.N., and John W. Parsons, M.D. Regional members to advise with the county draft boards are as follows:

Physicians

O. H. Binkley
Jacob W. Bird
H. A. Cantwell
Arthur H. Hawkins
Byrd Hopkins
James T. Marsh
Waldo B. Moyers
William D. Noble
A. Austin Pearre
Edward P. Thomas
Robert S. G. Welsh
Peregrine Wroth

Dentists

Thomas Bland
Crown O. Diehl
Stanley Mathews
James Russell Cook
Mayo B. Mott
Harold Conner

Veterinarians

H. L. Baker
F. S. Wharton
J. Walter Hastings, Sr.
Charles S. Koble
Fletcher Vinson

These gentlemen were authorized to augment their number wherever necessary to carry out the program as expeditiously as possible. It must be borne in mind that the first registration was to come only nine days after the appointment of the nucleus of the Advisory Committee. Haste was necessary. No one knew at the time to what extent this country might become involved in armed conflict. The Korean crisis had brought sharply into focus the serious lack of professionally trained personnel in the armed forces. Certain criticism has been voiced by county medical societies and local hospital groups that committees which had been organized under an earlier system by them were by-passed at this time. Our only reply can be that a new system had been created practically overnight at a national level. The emergency of the situation demanded haste and expeditious action. It could have been that we might have found ourselves with more committee members than special registrants to be processed. We can state with

just pride that Maryland was among the first, if not the first State, to have completed the processing of all professional men who registered on October 16, 1950.

We wish to take this occasion to thank all members of this group who have contributed their services voluntarily to this program. Some members have come long distances in inclement weather to attend hastily summoned conferences. It might be of interest to note here that the sum of $5,000 was allotted to this Committee for expenses for the period January 1, 1951, to June 30, 1951, and $1,000 for the year July 1, 1951, to June 30, 1952. Such is the lavish hand of government today. Actually the Committee has requested reimbursement for less than $50 up to the present time!

It would be a serious omission not to comment upon the splendid cooperation that has been shown this Committee by the Director of Selective Service, Col. Henry C. Stanwood, and the sixty-six draft boards in this State. The draft boards have concurred with the recommendations of the Advisory Committee in almost every case. By and large the same cooperation has been shown by the draft boards of other states with few exceptions. It must be emphasized, however, that the sole function of the Advisory Committee is to pass an opinion to the draft board concerned upon the professional availability or non-availability of a special registrant for military service. Physical disability, dependency, and financial hardship, when claimed, are ruled upon solely by the draft boards.

It is to be regretted that we cannot give accurate figures on the number of men processed under the first registration of October 16, 1950. This is so for various reasons. First of all, the draft boards do not report to us their decisions except in cases of appeal. To do so would add greatly to the heavy burden of their secretarial staffs, for whom the "doctor draft" is only a small part of their work. There are a number of doctors in training who are not residents of Maryland, but who registered at the time with Maryland boards. Conversely, there are a number of legal residents of this State temporarily residing out of the State, who have registered with out-of-state boards.

Up to the present there has been no attempt made to process professional men in Priority III (no military service since September 16, 1940) and those in Priority IV (veterans of World War II) with this exception. We have been requested by the National Advisory Committee to express an opinion upon the present status of members of the Reserve Corps of certain branches of the Service. This does not mean that those men contacted can look forward to recall into the Service within the foreseeable future, except for those reservists who were in Priority I and II under the Draft Act. It is planned to have an up-to-date appraisal of the professional status of each officer in the Reserve Corps in a file of the State Advisory Committee. The military forces have agreed that no reserve officer will be called to duty without consultation with the Advisory Committee.

In a recent article in the Journal of the American Medical Association, Dr. Howard Rusk has very aptly summed up the policy: "It is particularly significant, I think, that by mutual agreement the military services for the first time in history have permitted a civilian group to be placed between them and their reserves, and in the interest of total national welfare rely upon its advice and recommendations in calling their reserves to active duty." To comply with this agreement, it will be necessary from time to time to contact members of the Reserve Corps for pertinent information. It is requested that such men give our questionnaires their prompt attention. Otherwise the whole program can fall to pieces. This must not be allowed to happen.

In conclusion, we should like to comment upon the splendid coöperation that has been extended to us by the Surgeon of the Second Army, Fort George Meade, and the Offices of the Surgeon General of the Army, Navy and Air Force. We are pleased to report that not once has a request of ours for even a last minute deferment of an officer been refused, and in several cases it has required a great deal of prompt action to fulfil such request. It would be inappropriate to close without commenting upon the excellent coöperation shown by the superintendents of hospitals, the heads of departments of medical schools, and the chiefs of hospital staffs who have worked so closely with us. Finally, a word should be said about the Special Registrants themselves. We have had personal contact with a great many of them. We have been tremendously impressed by their willingness to sever their civilian

careers and enter the military services in this emergency. Most requests for deferment have been for a comparatively short period of time in order to complete a hospital year or to close a practice. The great majority who have been found eligible have already signified their intention to accept a commission in the armed forces, and a goodly number are already on active duty. No professional men from this State have been drafted into the Services as an enlisted man to our knowledge up to the present time. This is a record of which we can all be justly proud.

MARYLAND CIVIL DEFENSE MEDICAL SERVICES

DR. R. H. RILEY

Director, Medical Services Division

AND

H. G. FRITZ

Acting Deputy Director, Medical Services Division

The present status of the Medical Services aspects of Civil Defense is encouraging but not reassuring.

During the twelve months since responsibility for this phase of Civil Defense was placed with the State Department of Health on recommendation of the Medical and Chirurgical Faculty, specific policies and detailed plans have been developed in special fields by the appointed chiefs and their advisory committees. As policies and plans have been developed, they have been sent as Bulletins to Local Directors of Medical Services for execution. Twenty such bulletins have been issued.

The response of appointees to the State organization as chiefs and members of advisory committees and their diligence in meeting their assignments has been encouraging. However, their responsibility at the State level is limited to policy making and planning. Written policies and plans give no assurance of ability to meet an emergency such as can be expected following enemy action.

Local civil defense areas are autonomous and, therefore, responsible for the implementation and execution of recommended plans. Some encouragement can be derived from the reported progress of planning and organization in local defense areas. However, progress is not uniform. Where specific appointments have been made, they are limited to key personnel. No complete operational medical units have as yet been established.

There can be no assurance of readiness to meet an emergency until adequate personnel are trained and organized into operational units; until buildings have been committed; and until supplies and equipment are available.

The problem, therefore, is made up of three major factors which are:

1. People—recruited, trained and organized
2. Buildings—committed and specific plans made for their utilization
3. Supplies

PEOPLE

The most important resource is people. They fall into two groups. The first group is composed of professional people regularly engaged in medical fields. The second group, much larger and more flexible, is made up of non-professional people who must be given special training not only to survive but also to be capable of rendering service as members of operational units.

Questionnaires for physicians, dentists, nurses, pharmacists and morticians were prepared at the State level and distributed by Local Directors of Medical Services. Completed replies are being returned, in duplicate. Original copies are retained at

the local level for use in making assignments. Copies are sent to the State office to become a part of the master file.

Questionnaires were distributed and registration is being made on the basis of place of residence. However, assignments will be made following collaboration by the Local Directors of Medical Services of contiguous areas on the basis of choice of the registrant consistent with the most effective use of the candidate's training and ability.

Non-professional personnel is required in large numbers for Medical Services as well as for the other divisions of the Civil Defense organization, such as police, fire and welfare. The Red Cross offers training courses for such personnel in Home Nursing, First Aid, Canteen and Nurses Aide work. These trainees will be largely absorbed by the Medical and Welfare Services. In addition to these four groups of volunteers, there is need for volunteer auxiliary workers such as laboratory and x-ray technicians, administrative and maintenance personnel, and others.

Enrollment for a Red Cross training course is not a commitment for service in Civil Defense. The local Civil Defense organization assumes the responsibility of obtaining a commitment from trainees to accept assignments in the Civil Defense organization.

Professional and voluntary personnel are needed in large numbers in two of the four subdivisions of Medical Services. The subdivision for Medical Care needs volunteers in first aid to staff First Aid Stations and Casualty Clearing Stations. Other volunteers will be needed for the expanded hospitals. Planning for hospital services places upon existing hospitals the responsibility to expand to eight times normal capacity. It is quite obvious, therefore, that large numbers of both professional and non-professional volunteers will be required to service this tremendous expansion of hospital beds. Additional numbers of volunteers will also be required to render essential community services. This unit of Medical Services will be responsible for the non-casualty patients, that is, the usual home and office patients, of whom it can be anticipated there will be many.

The second subdivision which will require trained volunteers encompasses public health services. The sub units of this field of service include food and sanitation, industrial health, vital statistics and mortuary services, laboratory services and veterinary services. Volunteers will be needed for clinical and public health laboratory services and mortuary services.

The remaining two subdivisions are Special Weapons Defense and Supplies. Special Weapons Defense, which is defense against biological and chemical warfare, will be carried on largely by the existing Public Health Services. The public health laboratories will play a vital role. The subdivision responsible for Supplies will not require many volunteers beyond the planning and allocation, since supplies will be issued by the State Director of Civil Defense to the Local Directors.

Tables of organization for first aid stations, casualty clearing stations and hospitals have been prepared and published in Medical Bulletins or supplements to the Maryland Plan. Organization for a first aid station is made up of three first aid teams, each team having one leader and eight litter bearers, all of whom have been trained in first aid. In metropolitan areas, first aid stations should be organized on the ratio of one station for each four city blocks. The minimum number of first aid stations should be a ratio of five and preferably ten per casualty clearing station. First Aid Stations have been defined in the State plan as "... those points established as close as possible to the periphery of the damaged area to which litter bearers will carry casualties for transfer to vehicular transportation and to which walking casualties will be directed for First Aid. These First Aid Stations will function as advance posts and satellites of Casualty Clearing Stations. They will be staffed by first aid workers only. No physicians will be assigned to First Aid Stations."

Casualty Clearing Stations, according to the State plan, should be set up on a minimum ratio of one for each 10,000 population in populous areas. The table of organization for a casualty clearing station calls for 53 persons, including 2 physicians, 3 dentists, 3 registered nurses, 2 pharmacists, and 43 persons in the various categories of volunteer workers. Casualty Clearing Stations are defined in the State plan as "... established points to which casualties will be transported from First Aid Stations and where walking casualties will be received. At these

stations casualty teams, including physicians, will treat and process casualties to hospitals, homes or other dispositions."

A table of organization for emergency hospitals has been prepared and issued. This table calls for a a staff of 364 persons to staff a 500-bed emergency hospital, and 621 to staff a 1000-bed hospital. All types of personnel making up the usual hospital staff are required, supplemented by many volunteer workers. The ratio of personnel to beds is considerably lower than is normally found in a hospital for the reason that it is expected that all personnel will be on duty 12 hours per day, 7 days per week for the extent of the emergency.

It is quite apparent, then, that professional personnel in all categories are needed to complete the Civil Defense organization. Professional people who are not actively engaged in the practice of their professions are also needed. In addition to the professional personnel, great numbers of volunteers must be trained and assigned. Some progress has been made but practically all aspects of Civil Defense will have to be accelerated.

BUILDINGS

Buildings, like people, are existing resources which are limited to the number available. Since buildings cannot be constructed for Civil Defense purposes, it is incumbent upon Civil Defense administrators to improvise existing buildings for use as facilities needed to carry out the Civil Defense functions. Under Medical Services, buildings are needed for use as Casualty Clearing Stations and Emergency Hospitals. Minimum standards for buildings to be converted to these purposes have been prepared and issued. In most areas commitment for the use of buildings for Civil Defense purposes has been obtained and the buildings have been assigned to specific units. The progress is setting up organizational units to staff these assigned buildings is largely in the initial stages. Local Directors of Medical Services have been urged to expedite their recruitment and training programs so that staffs can be organized to function in the assigned buildings.

SUPPLIES

The supply question presents perplexities. Funds are not available at local, State or Federal levels for the purchase of all supplies which may be required. If funds become available in sufficient amounts for all states to satisfy their estimated needs, the vendors of supplies could not meet the demand. Most such suppliers are having difficulty meeting current demands for their products, to which have been added the defense demands. Because of this situation at this time, purchasing and stockpiling at the local level is limited to only emergency or first aid supplies. A plan has been discussed, which would establish depots of supplies at strategic points throughout the nation. Such depots would be located within four hours of all primary target areas. This is based on the assumption that four hours would be required to recover from the initial shock sufficiently to activate the Civil Defense organization beyond the First Aid Stations, the Casualty Clearing Stations and the expanded capacity of existing hospitals. Congress appropriated $50,000,000 for such stockpiling and purchasing is now in progress.

Federal funds in the amount of $314,000 have been made available to Maryland on a dollar for dollar matching basis for first aid supplies, blood plasma and antibiotics. The necessary matching State and local funds have been provided. A list of first aid supplies have been prepared and is under negotiation with Federal authorities for concurrence and purchase. The list includes those supplies which will be needed for the operation of Casualty Clearing Stations and their satellite First Aid Stations. Funds available for first aid supplies make possible the purchase of 150 units. These units will be allocated to Baltimore City and the 23 counties. They will be packaged in such a way that if they are not needed for local use they can be conveniently transported to a point of need.

Plasma and antibiotics will be stored with hospitals throughout the State. Storage in hospitals will permit the rotation of such perishables, thus avoiding loss from deterioration.

It can be reported, therefore, that considerable progress has been made toward organizing and developing Civil Defense Medical Services. Plans are in a satisfactory state of development. The organizational units are in the formative stage. It is expected that within a reasonable period of time Maryland's Medical Services for Civil Defense will be organized to a degree that in case of enemy action they

should be able to function effectively. No assurance, however, can be gained from this statement until organization and assignment have been completed.

NOTE. During the period since Medical Services for Civil Defense was made the responsibility of the State Department of Health, the program has been developed by Mr. H. G. Fritz, member of the State Department of Health staff, applying part time to Civil Defense activities. On December 1, General Robert P. Williams will report for duty on a full-time basis. General Williams will come to the organization with 35 years of military experience, including situations comparable to what might be expected to follow an atomic bombing. Having full time to apply to this work, it is expected that General Williams will be able to visit all of the local areas and effect an acceleration of their Civil Defense programs.

BUILDING FUND COMMITTEE

ALBERT E. GOLDSTEIN, M.D., *Chairman*

For the benefit of the members of the Medical and Chirurgical Faculty, we are very happy to give a report of the Medical and Chirurgical Faculty Building Fund Campaign.

In 1949, Dr. C. Reid Edwards, the General Chairman of the Sesquicentennial Committee of the Medical and Chirurgical Faculty, after a meeting with other members of his committee decided that some definite renovations and additions to the Library and building were necessary. A survey of the building was made, an architect was engaged and temporary drawings of the proposed outside structure were made. A finance chairman was named and he in turn named a large group of members of the Society to act with him on the committee. A number of meetings were held and wheels were set in motion to organize the Building Fund Campaign.

After careful consideration, it was decided to start a campaign to raise $300,000. This amount was considered necessary for our additions and improvements.

Members of the Committee chose names for individual solicitation. A plan was adopted to solicit city members first. It was decided that a minimum of $150 would be asked of each member to be paid over a period of three years. In some instances, larger pledges are being solicited.

The campaign started very satisfactorily with a contribution of five thousand dollars from the Baltimore City Medical Society and a five thousand dollar contribution from the Baltimore Obstetrical and Gynecological Section of the Baltimore Rh Laboratory, Inc. Seventeen Baltimore physicians pledged ten thousand dollars, in amounts ranging from five hundred to fifteen hundred dollars. This gave us a grand start of $20,000. There were many pledges ranging from one hundred fifty to three hundred dollars. The largest group met the minimum amount of one hundred fifty dollars. A smaller group who were solicited pledged between fifty and one hundred fifty dollars. The entire Committee worked very diligently and conscientiously through the entire hot summer of that year and into the fall and winter. Approximately 458 men were solicited, of whom 420 or approximately 92 per cent pledged for a certain amount. In all, better than $70,000 was pledged in that short time.

Along about that time many important incidents occurred, the most important of which was the activity in Washington to force Nationalization of Medicine on this country. Because of the above, it was necessary to temporarily halt our campaign and to become active in the fight against Nationalization of Medicine.

We were just about to become active again in our campaign when again we were forced to discontinue our drive because of the tremendous activity and campaign of the S.P.C.A. Their attempt to exclude procurement of dogs for research, posed a serious threat to the medical schools. A bitter battle was fought. We again discontinued our campaign so that we might participate in the fight by directing contributions from physicians to the newly formed organization known as the Maryland Society for Medical Research. After many difficult days and nights the Research Society won its battle. Since then, or about seven months ago, we have

again started planning for the renewal of our Building Fund Campaign.

In the meantime, there has not been complete rest for the Committee since several of us have visited many counties in order to familiarize members with our project. As yet, no definite campaign has been started in the counties. Nevertheless a few physicians have sent in pledges and checks which are surely appreciated.

In October 1951, various groups of the Committee were again assembled to renew with great vigor the solicitation of over nine hundred physicians in Baltimore City, never approached previously. So far only two hundred cards have been distributed to the Committee. A favorable report was recently brought in showing additional pledges of over four thousand dollars together with part payment checks. In the meantime, the Committee is working diligently. I would like to urge all readers to please lend courteous attention to any member of the Committee calling upon him. He is doing work for the good of the Society and for the benefit of every member. We are certain that every physician is going to do his share to the best of his ability. We are hoping each member can pledge at least one hundred and fifty dollars, payable over a period of five years if he desires. This contribution is tax deductible. With a $11\frac{3}{4}$ per cent increase in income tax, one can readily see that his contribution is not going to cost him a great deal.

The amount of money collected is going to be expended principally on the Library and to improve and enlarge the Osler Meeting Hall and other meeting rooms. It is the desire of the Committee to arrange in the new structure ample seating facilities, comfortable chairs, good lighting and acoustics, smaller meeting rooms for sectional groups, facilities for exhibitors at our semiannual and annual meetings. Improved rest rooms, air conditioning, a modern kitchen and supper room, portrait rooms and many other facilities that cannot be enumerated at the present time are also being planned. With each contribution that is made, opportunities are going to be offered to our members for establishing memorials. We are certain that many of our members will be interested along these lines.

Up to the present time we have actually collected approximately $56,000 which is drawing interest each day.

Do you understand the value of our present building and Library? From an insurance standpoint we are appraised at a value of over $250,000. Our Library is now considered the fifth largest medical library in the United States, carrying approximately 53,000 volumes of medical books and 22,000 volumes of medical journals. These are for use of any member of the Society wherever he may be located. In another year at the rate the Society is purchasing new books and subscribing for additional journals and binding the old ones, we will be unable to handle the situation. Part of the collected fund is to provide for ample facilities for parking of cars.

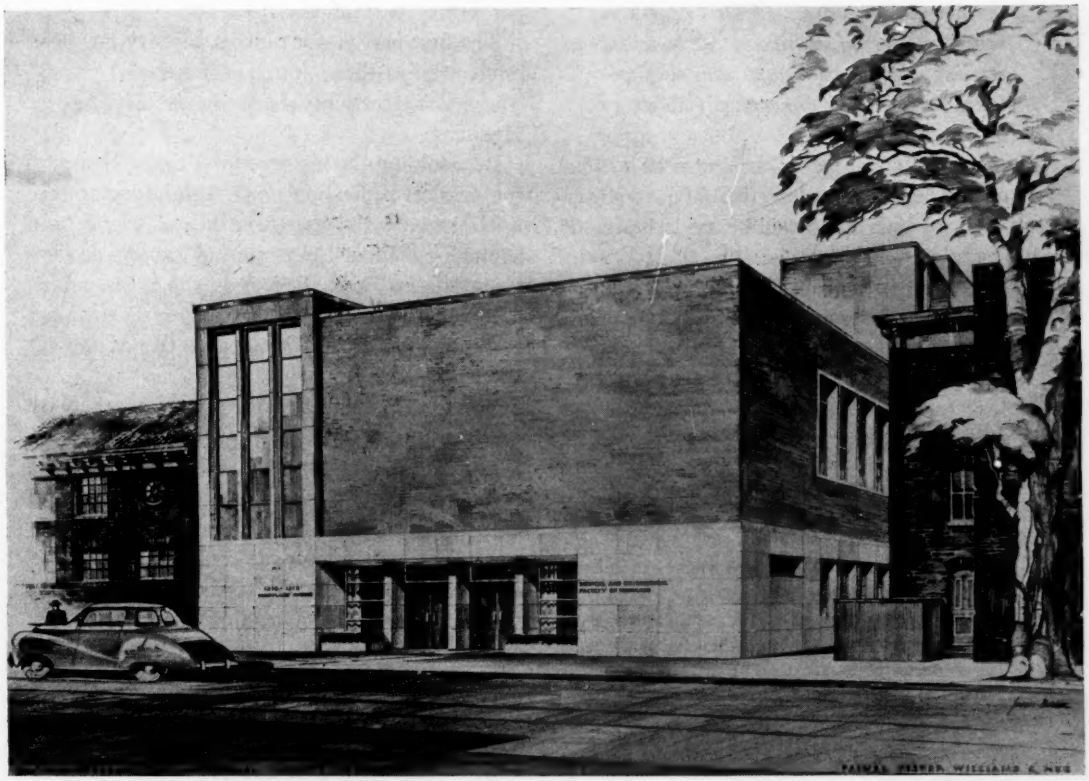
It is quite possible that after our total amount is collected it might be considered feasible to consider a new location rather than add to the present building. Every member will have a say in that direction. However, the immediate prime objective is to raise the initial amount. We can only make our campaign successful if each member in Baltimore City and in the Maryland counties will do his share by pledging some part of the amount to be raised. We are certain that the Baltimore City men are doing their share by the way they are responding. We do not question that when we start an active campaign in the counties that they will likewise desire to do their share in this great and necessary undertaking.

In view of the fact that each man is going to be approached, it might be well to inform our readers of the entire Committee. From this list one can readily observe that very busy men are willing to give their time in this project. Won't you please help us make this a success?

Sesquicentennial Committee (New Building): C. Reid Edwards, *General Chairman*, Baltimore; Albert E. Goldstein, *Chairman, Finance Committee*, Baltimore; John W. Parsons, *Treasurer, Finance Committee*, Baltimore; R. Walter Graham, Jr., *Chairman, Building Plans*, Baltimore.

Subcommittee—Finance Committee: Thurston R. Adams, Baltimore; Warde B. Allan, Baltimore; James G. Arnold, Jr., Baltimore; Walter A. Baetjer, Baltimore; Alan Bernstein, Baltimore; C. Bernard Brack, Baltimore; Leo Brady, Baltimore; Otto C. Brantigan, Baltimore; Henry Briele, Salisbury; Edwin N. Broyles, Baltimore; Ferdinand E. Chatard, IV, Baltimore; Beverley C. Compton, Baltimore; Newland E. Day, Baltimore; Louis C. Dobihal, Baltimore; Louis H. Douglass, Baltimore; Monte

Edwards, Baltimore; J. M. T. Finney, Jr., Baltimore; Wetherbee Fort, Baltimore; Francis J. Geraghty, Baltimore; Thomas K. Galvin, Baltimore; Mark E. Gann, Baltimore; Robert W. Garis, Baltimore; Lewis P. Gundry, Baltimore; Alan F. Guttmacher, Baltimore; Louis P. Hamburger, Sr., Baltimore; H. Hanford Hopkins, Baltimore; Harry C. Hull, Baltimore; J. Mason Hundley, Jr., Baltimore; Robert L. Jackson, Baltimore; Page C. Jett, Prince Frederick; Hugh J. Jewett, Baltimore; Marius P. Johnson, Baltimore; Walter L. Kilby, Baltimore; E. Paul Knotts, Denton; Amos R. Koontz, Baltimore; Edward F. Lewison, Baltimore; E. T. Lisansky, Baltimore; Perrin H. Long, Baltimore; Helen I. Maginnis, Baltimore; W. Kenneth Mansfield, Baltimore; Erwin E. Mayer, Baltimore; Karl F. Mech, Baltimore; Waldo B. Moyers, Mt. Rainier; W. Raymond McKenzie, Baltimore; Samuel McLanahan, Baltimore; Emil Novak, Baltimore; Frank J. Otenasek, Baltimore; Daniel J. Pessagno, Baltimore; Esther L. Richards, Baltimore; Harry M. Robinson, Jr., Baltimore; Alexander J. Schaffer, Baltimore; Fred B. Smith, Baltimore; Howard C. Smith, Baltimore; Richard W. TeLinde, Baltimore; Edward P. Thomas, Frederick; W. Houston Toulson, Baltimore; I. Ridgeway Trimble, Baltimore; Henry F. Ullrich, Baltimore; Lawrence R. Wharton, Baltimore; Walter D. Wise, Baltimore; Austin H. Wood, Baltimore; Alan C. Woods, Baltimore; Israel S. Zinberg, Baltimore.



PROJECTED BUILDING FOR THE MARYLAND AVENUE ENTRANCE

Scientific Papers

MIDCENTURY CHALLENGE

A. AUSTIN PEARRE, M.D.

Presidential Address[1]

Innumerable thoughts have been expressed to the Medical and Chirurgical Faculty that deserve a fate much more worthy than oblivion. It is proposed from time to time to abstract certain of the addresses presented before the Medical and Chirurgical Faculty. It is believed that the abstracted address of Dr. Pearre is representative of a timely subject. Its reading should eliminate mental platitudes and inspire the active interest of all.

Thomas Jefferson had ideas, and if he was not a prophet, he certainly gave his fellow countrymen advice which could well be used at present, 150 years later.

Some excerpts from his inaugural are timely and deserve perpetuation in the history of our country.

"With all these blessings, what more is necessary to make us a happy and prosperous people? Still one thing more, fellow citizens—a wise and frugal government, which shall restrain men from injuring one another, which shall leave them otherwise free to regulate their own pursuits of industry and improvements."

"... Economy in the public expense that labor may be lightly burdened ... the honest payment of our debts ... They should be the creed of our political faith ... the touchstone by which to try the services of those we trust, and should we wander from them in moments of error or alarm, let us hasten to retrace our steps and to regain the road which alone leads to peace, liberty, and safety."

Mr. Jefferson's principles and policy were so popular that Congress passed an act for redeeming the public debt.

[1] Annual Meeting, Medical and Chirurgical Faculty, April 25, 1950.

It is interesting to ponder on the reaction of the statesmen of that era, could they have foreseen that 150 years later their country would be burdened with a national debt of 258 billion dollars and an annual budget proposal of $42,435,000,000, representing additional deficit spending at the rate of over 5 billion dollars per year.

The first half of our present century has been referred to as those "terrible, wonderful years." These have certainly been the Golden Age of Medicine.

In moulding the history of our times, however, the medical profession must certainly share the world stage with other branches of science and technology. Indeed our military leaders deserve the spotlight. From the standpoint of the public, however, the man of our century may turn out to be the politician, if present trends are allowed to continue.

The years since 1900 have been marked by social restlessness. An editorial in the *New York Times* of January 1, 1950, points out—"There is a connection between the restlessness and scientific advance. Airplanes, automobiles, electron tubes, radiotelephonic communications and broadcasting, television, radar, synthetic rubber, ... the release of atomic energy—we saw these evolve before our very eyes. Labor-saving machines in mass production are being used more and more."

"Most of our economic and labor problem, are the direct result of technologic innovations and technologic innovation in turn springs from scientific research." Electronics and relativity may play even a greater role in the future, and

one shudders at the mere mention of the words "hydrogen bomb."

With such obvious reminders as the development of aviation, we are necessarily made to think of our globe as becoming smaller and smaller. As the world becomes smaller, the individual looms larger. His individual welfare must indeed be given more and more consideration.

No one can deny that in these past 20 years there has been a rapid trend toward the centralization or nationalization of power, not only in European countries, but in the United States.

As we try to analyze the factors which have created conditions leading to a so-called "welfare state," while it is certainly true that much influence in this direction has arisen from Russia as an aftermath of Marxian philosophy, and also from Germany as a result of ramifications arising from Bismarck's militaristic superstructure and policy of "Germany for the Germans," we must not lose sight of the fact that trends in this direction have been slowly evolving on this side of the Atlantic, too.

Many of you physicians who are here tonight will probably remember that before the last century ended there were periodic outbursts calling for the expansion of the social functions of the state. You may recall Mr. William Jennings Bryan's efforts and his Cross of Gold speech in 1896. Later came President Theodore Roosevelt and his "Square Deal." In 1900 Mr. Samuel Gompers was developing his American Federation of Labor to counteract the power of big business.

In the early years of the century emphasis began to be placed in these United States more and more on quantity and material progress. Everything was to be bigger and better. The development of the automobile industry showed the trend of our industrial growth.

Mr. Taft's 61st Congress was the first to recognize the principle that the great corporations could be taxed.

The first graduated tax on individual incomes to stick, authorized in the 16th Amendment, became part of the tariff law in 1913.

We became accustomed to depend on Britain as the banker, educator and policeman to the world.

In Germany with the subsidence of the Franco-Prussian War, the enormous increase of the class of factory workers attendant on the rapid development of Germany into an industrial state, and the growth of radical doctrines among their ranks, made Bismarck see that new measures would be necessary. He thought it wise to offer the workmen permanent economic advantages through state guaranteed insurance against sickness, accidents, old age and disability. He wanted to show them that they might expect substantial advantages from the existing form of the state.

In 1911 both Great Britain and Russia adopted compulsory health insurance and other parts of Bismarck's plan.

During the active span of the lives of most of us here tonight, we have seen the world shaken by the two most catastrophic wars of all time.

World War II has also been followed by general restlessness and lack of confidence. At the present time more and more people seem to require sedatives or alcohol in order to keep going. Observe the mounting tension as we daily drive in traffic.

War, of course, provides a fertile soil for the roots of taxation. "The most important economic aspect of income taxation is naturally its effect upon the capacity and psychology of the taxpayer, for these may affect his willingness to work and to save, and thus have important reactions upon national production."

There can be no objection to paying a debt incurred in the defense of our country against Germany and Japan. This is the very least we can do. Deficit spending to the tune of 5 billion dollars a year in peacetime, however, must be stopped, since nearly all of this excessive expense arises from so-called "non-war connected domestic functions." Today, you and I devote nearly one-third of our working time and effort to supporting our Federal, State and local

governments. Tax rates on personal and corporation incomes have more than tripled in the past 20 years. One amazing feature of our present tax system is that in some instances we pay taxes to the Government only to have the Government bring our tax dollar back to compete with us at home.

Mr. Earl Bunting of the National Association of Manufacturers, tells us that we are no longer able to invest some 20% of our gross national product in new tools and machines.

Remember that without Mr. Ford's millions plowed back into his business, there would be no 60,000 jobs at River Rouge!

Since the last election in which Mr. Truman became President in his own right, the "Fair Deal" really is becoming a delusion of grandeur. It has been formally unveiled before the 81st Congress, and at its second session, federal aid to education, compulsory health insurance, expanded social security, the farm parity program (Brannan Plan), etc., add form and substance to the "welfare state." Senator John L. McClellan has estimated that 15 of the major proposals now before Congress would add within the next 4 to 5 years an additional 25 billion dollars per year to our already deficit spending yearly budget of 42 billion dollars.

"To alleviate such evils as irregular employment, inadequate income and other manifestations of maldistribution, we are now asked to expand our social security system to provide a floor of protection for all."

The recommendations for the program proposed are definitely compulsory on the individual and to be administered primarily by the Federal Government at tremendous expense. The effect on the national economy of meeting the cost is completely ignored. While there exists hardly a doubt as to the desirability of social security as a principle, according to Mr. Gerhard Hirschfeld, of the Research Council for Economic Security, "the cost may become so high as to render impotent the productive genius which is the foundation of our economic system."

In the past. security has meant ability to work hard and ambition to get somewhere. Today people have come to think of security in terms of safety without a struggle, of freedom from worry, of protection against sickness, unemployment, old age. Private financial security is the reward of enterprise; public financial security takes its concept from the failure to create a steady income, (which is not necessarily one's own fault). We all know that insecurity frequently arises from the neglect to budget expenditures, from the unwillingness to sacrifice some leisure and pleasure for a program of hard and constructive work, and finally from a readiness to rely upon others for economic support or assistance. "In good times there is very little unemployment that is not voluntary." Members of the Faculty, we are confronted with a new epidemic disease. *The Virus of Welfaritis is destroying the life blood of Democracy and is leading to the anemic state of socialism.*

Too many of us are asking the Federal Government to do for us what our grandparents would have done for themselves.

Thousands of years ago, Cain asked the Lord, "Am I my brother's keeper?" Throughout all the period of civilization that has followed, we still must ask how far can we help a brother in need without adding to his dependence. Algernon Sidney has said that "God helps those who helps themselves." Shakespeare tells us "it is not enought to help the feeble up, but to support him after."

Certainly idleness is always bad, and I often wonder how long the formula of more pay for shorter hours will work. Is it possible to create a surplus on a 40-hour week? Can more money for less work be eventually as dangerous as an atomic bomb? Perhaps being able to produce more with less effort may be the product of modern efficiency, but somehow I still admire our older generation, who desired through their spirit of free enterprise, to work long hours, and to have the benediction of the village blacksmith pronounced on their day's effort—"Something accomplished, something done; he has earned a night's repose!"

Dr. Charles R. Brown, former dean of the Yale Divinity School, once answered this question, "Am I my brother's keeper?" with an emphatic "No!" Then he added, "I must be my brother's brother." This recognizes his right to be himself, his desire to be a free agent. This attitude respects our brother's self-respect.

Freedom itself must be defined. When you speak of freedom, are you thinking of freedom from or freedom for? Freedom from may be very selfish, whereas, freedom for—being free to serve, implies the assumption of responsibility which should be every normal person's desire. The acceptance of any freedom should carry a moral obligation on the part of the recipient that he will not abuse the privilege of that freedom.

Franklin B. Snyder, President of Northwestern University, in a "Charge to the Graduating Classes," said:

> "I hope that fifty years from now freedom will still exist in this land of ours. I hope we shall not have been enslaved by either an all-powerful Federal Government in Washington, or by debt, much of it incurred in the name of a vague concept called 'security', which will inevitably crush all initiative. . . . The concept of freedom which we Americans cherish is a many-sided one. It implies freedom to fail as well as to succeed."

CRADLE TO GRAVE

Our social planners would like to remove all elements of conflict, of struggle, of hazard, from life; they would extend security as proposed by Sir William Beveridge, "from the cradle to the grave."

As Mr. Justice Holmes put it "security is generally an illusion." "Slavery imposed by a planned economy can be much worse than that of poverty or disease." We are repeatedly being warned by a few very excellent governmental diagnosticians.

Mr. Herbert Hoover, on his 75th birthday, declared in an address at Stanford University, that "through Government spending and taxes, our nation is blissfully driving down the back road to collectivism and is on the last mile."

Senator Byrd in his speech on October 12th, at Atlantic City, warned again of our deficit spending. He certainly gave every thoughtful American reason for serious contemplation when he said, "every time your watch ticks while I am making this speech, the Federal Government will be spending $210 more than it takes in." This adds up to over 18 million dollars a day that our Government, in a peaceful year, is going farther into debt, and yet the Administration continues its attempts to expand a radical social security program. Should we not all listen to the warning of the Senator from Virginia when he states that "America is on the march to socialism, and the pace of the march is increasing to the tempo of expanding federalized programs and increasing national debt."

Truly, as Mr. Babson states, "We in the U. S. need to be acquainted with the economic facts of life."

Senator Byrd has further warned that Marxist socialism and our welfare state program are "twins of evil" and we must fight them. Members of the Faculty, we now are able to recognize the signs and symptoms of these new diseases, although their onset has been very insidious. *We know that the best social security is that which comes from a steady job, hard work and good wages.* "In order to provide this highest type of social security, it is necessary to create the conditions which are conducive to a full productive economy." A reduction in the number of working hours means that even a higher scale of wages causes no appreciable rise, if any at all, in net income. "We shall never progress by placing a premium upon idleness while putting a damper on enterprise."

If people are allowed to work more productively, they are able to save more for their individual futures. Dr. Osler has reminded us that work is the master key to success. This was true in 1900 and it is still true in 1950.

The physician here at mid-century, in addition to being a good doctor, now finds it necessary to be a crusading citizen. This has not been easy for him to do because he has always, in the past, innately shunned publicity. It is, however,

possible for us as physicians to assume this new duty since such an effort is required to meet the threat of epidemic "welfaritis." All physicians are trained to meet emergencies. Individual effort on the part of doctors is our weapon against this spreading disease and we can expect no help from antibiotics or from hormones.

We must be constantly mindful, with David Hume, that liberty of any kind is seldom lost all at once.

We cannot close our eyes or turn our heads away while politicians destroy our system of free enterprise which has made America the greatest nation in the world, and the only nation in the world strong enough to give real aid to the rehabilitation of other nations weakened by war.

We must remember that there are two ways in which liberty can be lost. It can be taken from without, and twice during the first half of our century it has been necessary to resort to stupendous war efforts to preserve our freedom. Remember, however, that liberty can also be lost through forces from within.

The chief difference between socialism and communism is that liberty dies a little more slowly under the influence of socialism.

When we read of the rapid spread of communism, isn't it urgent for every citizen living in a democracy to do some real thinking?

Is it significant that in January, 1945, Moscow ruled 190 million human beings, and that by November, 1949, she ruled 800 million of the world's people—one-third of the human race?

Physicians here and now must take an active interest in government and in world affairs. It is certainly a responsibility of ours, as American citizens, to choose, with care and thought, those who represent us in government. It is further necessary for us to keep ourselves informed as to current problems and we have every right to expect our legislators to conduct themselves as statesmen. It is vital that our representatives should think more of the next generation and less of the next election.

I believe that the average physician, as we pause at mid-passage of this momentous century, feels privileged to share achievement with the scientist and the militarist. Experience abroad, however, has shown that the politician and the bureaucrat should never come between the doctor and his patient. We insist that politics must be kept out of the science of medicine.

In our time, we have seen that wars have created as many problems as they have solved. In looking into the future we, as citizens, must all recognize that our first major responsibility is to do everything in our power to aid in securing world peace. This goal must be attained. We owe its accomplishment not only to those who have sacrificed so much for us in the past but to our children and those generations yet to come. Certainly we must not become anemic through internal occult bleeding. We know that free countries have been undermined from within.

Our present trend toward socialism, like many disease processes, is reversible. We must preserve Freedom and Opportunity, and while still free to serve, must put our whole hearts into hard work. Our guiding force must be not what I deserve, but how I can serve. Freedom of choice, voluntarily made by free people, makes America really the land of opportunity. We have an unmatched record of achievement under a system of free enterprise created by the American people through their own efforts.

We, in America, should give more and more thought to moral and spiritual values. Material things, though necessary, are not alone enough to satisfy man.

Our immediate challenge is to live and to practice more democracy. We must build up, once again, the energies of a free people by following the example of the beloved country doctor who, through the years, has always been willing to work harder and sacrifice more for the common good because of his love of humanity associated with the love of his work.

MEDICOLEGAL SYMPOSIUM—DRUG ADDICTION

The Medical and Chirurgical Faculty, in conjunction with the Baltimore Bar Association, has formed a joint committee with the following objectives:

1. To consider the problems of the lawyer in the practice of the legal profession wherein they relate to the doctor in his practice of the medical profession, and
2. To develop discussion of problems of mutual interest, and
3. To provide by way of open forums of the two professions, a discussion of problems of mutual interest, hoping to attain a better understanding of such problems and arriving at a solution thereof.

The idea originated in the Institute of Medicine of Chicago, and basically the Maryland Committee has patterned its activities along lines suggested by the Chicago group. A series of open forums for the interchange of information is contemplated. The first forum which discussed the problem of Narcotic Addiction was held in the building of the Medical and Chirurgical Faculty on Saturday, October 13, 1951. The joint committee is composed as follows:

The Baltimore Bar Association—Mr. G. C. A. Anderson, Mr. R. D. Bartlett, Mr. C. Barton, Mr. S. C. Berenholtz, Mr. J. Bernstein, Mr. W. L. Galvin, Mr. A. A. Levin, Mr. M. P. Smith, Mr. A. Sodaro, Mr. J. S. Stanley, Mr. T. C. Waters. The Medical and Chirurgical Faculty—Dr. C. Acton, Dr. L. Brady, Dr. R. S. Fisher, Dr. M. S. Guttmacher, Dr. L. A. M. Krause, Dr. C. A. Reifschneider, Dr. R. C. Tilghman, Dr. I. R. Trimble, Dr. H. F. Ullrich and Dr. T. C. Wolff.

Participants in the Panel Symposium on Drug Addiction were: (1) Pharmacology of Drugs Causing Addiction. Earl H. Dearborn, M.D., Assistant Professor of Pharmacology, The Johns Hopkins University School of Medicine. (2) Criminal Prosecution of Drug Cases. Mr. Anselm Sodaro, States Attorney of Baltimore City. (3) Judicial Administration of Drug Cases. Judge Joseph Sherbow, Baltimore. (4) Care, Treatment and Rehabilitation of Drug Addicts. James V. Lowry, M.D., Chief of Community Services Branch, National Institute of Mental Health, Bethesda, Maryland. (5) The Problems Presented to the Youth of the Community by the Traffic in Drugs. Mr. Roszel C. Thomsen, Member of the Bar and President of the Baltimore City School Board.

It is believed that their remarks are extremely important, timely and applicable to the entire State. Important phases of the discussion are hereby reproduced. Additional parts will be reproduced in forthcoming issues.

THE PHARMACOLOGY OF DRUGS CAUSING ADDICTION

EARL H. DEARBORN, PH.D., M.D.

Assistant Professor of Pharmacology and Experimental Therapeutics, The Johns Hopkins University

Addiction is a term which has been used in very loose fashion in recent years; therefore, at the outset of this discussion I would like to define it as a pharmacological phenomenon. It may be said that there are three essential factors in addiction, namely, HABITUATION, TOLERANCE, and PHYSICAL DEPENDENCE.

Habituation is a state of psychic or emotional dependence in which the individual becomes accustomed to the effects of the drug and, as with all habits, suffers some mental disturbance when it is interrupted. Since this is purely a subjective phenomenon, it can be studied only in man and then only with considerable difficulty.

A great many drugs may bring about habitua-

tion. Stimulants such as caffeine or amphetamine; sedatives such as acetanilid or bromides; hypnotics such as chloral, paraldehyde, alcohol, marihuana, or barbiturates; and even such a common substance as tobacco may bring about the formation of a drug habit. However, by far the most marked degrees of habituation are produced by cocaine or morphine or various morphine substitutes. Cocaine gives a marked euphoria usually accompanied by increased activity. Morphine and its substitutes also produce marked euphoria though it is not accompanied by increased activity. Heroin gives the most marked euphoric effect of any member of this group. The euphoria caused by this group of drugs seems to be closely associated with not only their tendency to produce habituation but with their ability to relieve pain. For example, Isbell and his associates have found that l-methadon produces euphoria, habituation, and relief from pain whereas d-methadon exhibits virtually none of these effects.

Tolerance is the term applied to the situation in which an individual or animal must be given successively larger and larger doses of a drug to produce the same pharmacological effect. Tolerance does not always develop following chronic administration of habituating drugs. Chronic use of caffeine, amphetamine, acetanilid, bromides or marihuana in all probability does not result in the development of tolerance to their actions on the central nervous system. Very slight tolerance may develop after chronic use of chloral, paraldehyde or tobacco.

Although there is no conclusive evidence that tolerance to alcohol develops in man, it is widely believed that it does. Animal studies indicate that it might be demonstrable if properly controlled experiments could be carried out in man. In dogs, Newman and Lehmann measured the degree of intoxication produced by a dose of alcohol given intravenously. This was followed by a period of ninety-seven days during which the dogs were habituated to alcohol. Then the degree of intoxication following the same intravenous dose was again measured and found, in all cases, to be significantly less than it had been before the period of habituation. This provides a conclusive demonstration of the production of a moderate degree of tolerance to alcohol in the experimental animal.

Attempts to demonstrate tolerance to barbiturates in animals have not been too successful. Occasional authors have felt that some slight tolerance to the hypnotic effect was observed, but in view of the marked variability in the responses of the same animal at different times one must regard these as probably insignificant. No tolerance to the toxic effects has been observed. Numerous reports of chronic barbiturate intoxication in man have appeared in the literature. However, it is impossible to determine whether any significant degree of tolerance exists, because of the variability in the response of any given individual at different times.

In a recent study carried out at the government narcotic hospital at Lexington, Kentucky, Isbell and associates administered large doses of secobarbital, pentobarbital or amobarbital to five former morphine addicts for periods ranging from ninety-two to one hundred fourteen days. During the early part of the period of intoxication the dose was increased somewhat, but the authors found it impossible to determine whether or not any tolerance was produced. However, readministration of the same dosage sixty to ninety days after withdrawal resulted in a much more severe intoxication than was seen during the chronic administration. In fact, it was necessary to discontinue the drug after twenty-four hours to avoid endangering the lives of the subjects, yet they had previously tolerated this same amount of drug daily for a number of days. The evidence suggests that some tolerance to barbiturates may occur, but it is not likely that it is of a very large order or magnitude.

There is general agreement among those who have studied the problem that no tolerance to cocaine has been shown in animals. Some have reported its occurrence in man; however, it seems likely that when an individual begins to take cocaine he increases the dose progressively until

he has determined the maximum dose he can tolerate. Once having determined this maximum, he may abstain for long periods and then return to the drug taking the same dose. This cannot be done with any drug to which marked tolerance is developed.

Tolerance to morphine or its substitutes can be developed to a very high degree. Light and his colleagues in their classic study record that they were able to administer *two grams* of morphine intravenously in two hours twenty-four minutes to an addict without any change in pulse, respiration or blood pressure. This dose was approximately nine times his regular dose and is around one hundred times the amount that could be given to a normal individual. Tolerance to morphine or one of its substitutes confers some degree of cross-tolerance to other members of this group.

In rats and dogs, tolerance to the analgesic and general depressant actions of morphine and its derivatives and methadon is readily developed. Tolerance to the depressant action of meperidine has also been demonstrated. In these and other lower animals death from morphine or its substitutes results from convulsions. No tolerance is developed to this lethal action of morphine, and it seems likely that this would also be true of meperidine and methadon. In monkeys and man, stimulation is less marked and death when it occurs is due to respiratory depression; hence, tolerance to the lethal effect develops along with tolerance to the general depressant effect.

Tolerance need not be associated with psychic or physical dependence. For example, the body tissues may become tolerant to nitrites which do not produce either type of dependence.

Physical dependence is the state in which the body has become so accustomed to the presence of the drug that it cannot carry out its physiological activities in a normal manner without it. When the addict is deprived of drug and its effects begin to disappear, physical dependence is manifested by the abstinence syndrome, otherwise known as withdrawal symptoms. Physical dependence either is not known to occur or is insignificant after the use of caffeine, amphetamine, bromides, acetanilid, chloral, paraldehyde, marihuana, tobacco or alcohol. Physical dependence to cocaine is much less than with morphine.

With barbiturates irritability and convulsions have been observed in dogs, but no symptoms have been seen in monkeys on termination of periods of chronic intoxication with barbiturates. There are a number of descriptions of the occurrence of psychoses or convulsions or both in patients deprived of barbiturates after periods of chronic intoxication. The best description is given by Isbell in his exhaustive study of five former morphine addicts. On withdrawal of the drugs, the signs of intoxication were superceded in twelve to sixteen hours by weakness, tremor, anorexia, nausea and vomiting, rapid weight loss, increase in pulse and respiratory rates, fever, and increase in blood pressure with difficulty in making cardiovascular adjustments when standing. Frank psychoses resembling delirium tremens were seen in four of the five patients and convulsions resembling grand mal epilepsy were seen in four of the five. The symptoms were at their worst from thirty-six hours to five days, following which they gradually declined in severity, and by sixty days recovery was complete.

Symptoms of physical dependence to morphine or its substitutes following withdrawal are as follows. At first, only mild symptoms such as perspiration, runny nose, excessive flow of tears and yawning are seen. These become progressively worse and gooseflesh, dilation of the pupil, loss of appetite and muscular tremors appear. Then insomnia, restlessness, increased rate of breathing and elevation of the blood pressure develop, and as the syndrome reaches its fully developed state vomiting, diarrhea and weight losses as high as fifteen pounds in twenty-four hours may occur. This is a strenous ordeal and may culminate in collapse and shock even in healthy individuals. In an aged or infirm addict withdrawal of the drug may result in death. This fact is recognized

in the Harrison Narcotic Act. With morphine or heroin these symptoms increase during a period of thirty-six to forty-eight hours after which the severity decreases. Five to seven days, after the last dose of drug only nervousness, insomnia and weakness remain. These gradually disappear over a period of several weeks to six months. Withdrawal symptoms resulting from discontinuance of meperidine are less severe than those from morphine, reach maximum intensity more quickly, and disappear more rapidly. Those from methadon withdrawal are less severe but much more prolonged than those of morphine, and those from codeine are quite mild.

Physical dependence has been produced in a wide variety of animal species but only in the dog and monkey are the withdrawal symptoms sufficiently similar to those in man to make them of value in studying drugs of this general type. Withdrawal of codeine or meperidine does not cause symptoms in dogs though they occur following methadon withdrawal. In monkeys, codeine gives minimal symptoms and meperidine and methadon essentially none. It is obvious that studies of physical dependence in animals are of limited value.

In man the establishment of a diagnosis of addiction rests upon the demonstration that withdrawal symptoms occur on stopping the drug and on their disappearance upon readministration of the drug. It has been found that individuals addicted to morphine or one of its substitutes can be relieved of withdrawal symptoms at least in part by administration of other members of this group. It is the general feeling that any drug which will relieve the abstinence syndrome of morphine is at least potentially an addicting drug; hence, it is the present custom to consider it so until evidence to the contrary is presented. In the past, many new drugs have been introduced for the treatment of pain, and in each case the claim has been made that they are not addicting. However, the above test for addiction potentiality has, in each case, been borne out by the subsequent appearance of cases of primary addiction which present themselves for treatment at the Government hospitals at Lexington and Ft. Worth. Many of the hypnotic drugs such as barbiturates may give a slight relief from withdrawal symptoms which is probably related to their depressant action, but notable relief is given only by drugs which in the end have proven to be addicting.

As I have defined it addiction is a purely pharmacological phenomenon consisting of a reaction between a drug and an organism by means of which HABITUATION, TOLERANCE, and PHYSICAL DEPENDENCE are developed.

The most serious and deleterious effects of addiction are the secondary ones which result from the imperative need of the addict to have his drug regularly. His need for drug comes to supercede all other objects in life and results in moral collapse so that he will sell any possession, steal, rob or even murder to obtain a supply. In closing, I wish to emphasize that it is not the addiction per se which is harmful to the morphine addict. When he has adequate supplies of drug, he can carry on a normal life and cannot be told from a normal individual even with exhaustive studies, as was shown by Light and coworkers. Addiction to cocaine or meperidine or habituation to alcohol or barbiturates, on the other hand, may be much more dangerous as there are usually definite signs of intoxication in those taking these drugs.

Including the social consequences of addiction in the definition of the phenomenon, as has frequently been done, serves only to confuse matters. It is akin to saying that the intoxicated individual who drives a car successfully is not drunk whereas he who has an accident is drunk. In addition, it is obvious from this discussion that there are drugs which may have socially detrimental effects which cannot be considered to be addicting.

PROSECUTION OF DRUG CASES

ANSELM SODARO, ESQ.

States Attorney of Baltimore City

Introduction by:

CHAIRMAN THEODORE C. WATERS: To the office of State's Attorney of Baltimore City is assigned the prosecution of Drug cases in our Criminal Courts. This is an essential phase of the administration of justice and when dealing with Drug cases calls for tact, discretion and determination to control the traffic of drugs. Anselm Sodaro has distinguished himself in the administration of his office and has assumed and discharged with ability the prosecution of drug cases. It is my pleasure to introduce our distinguished State's Attorney, Mr. Sodaro.

STATE'S ATTORNEY SODARO: Mr. Waters, Mr. Stanley, Dr. Wise, Ladies and Gentlemen, the Narcotics traffic is a heinous, commercial racket which thrives on the slow, painful annihilation of its victims. To quote the Honorable Harry J. Anslinger, Federal Commissioner of Narcotics, "The Narcotics peddler does not kidnap children, he destroys them." This racket must be dealt with vigorously and relentlessly. The drug problem should be the vital concern of the entire community, not alone of law enforcement officers and the Medical profession.

No greater menace to society exists than that which is presented by syndicated, commercialized narcotics operations. Manifest to all is the regrettable breakdown of the moral and spiritual life of our citizens. In too many places it is no longer regarded that the education of our young should embrace any reference to Religion.

There has been an over-emphasis on the material development of our youth at the expense of their moral training. There has been evidenced too much delegation and transfer of parental authority of our youth. Parents have been entirely too eager to relinquish this authority and responsibility. The home seems to be no longer the center of attraction and the proper place for the moral education of our juveniles. Responsibility for any breakdown in our social fabric should be attributed to the individual home. As one eminent columnist recently said: "No matter what progressive educators say about the social value of self-expression in a Democracy, children who grow up like alley cats without moral restraint and inhibition will not resist the temptations of their environment. These restraints and inhibitions must be developed in the home."

The dual problems of organized crime and juvenile delinquency have a common cause in that there is present an alarming indifference to the accepted moral standards. It has always been my belief that full exposure of the nature of the problems to be dealt with is imperative if we wish to administer corrective measures. It is clear therefore, that this deterioration of moral values has brought about an increase in juvenile delinquency and criminality, and has given encouragement to the heartless miscreants who profit out of the distress and misery of their unsuspecting victims.

Prior to 1945 there were in our country very few individuals below the age of twenty-one under investigation in connection with the use of narcotics. By 1946 the situation was changing and three per cent of the addicts treated by the U. S. Public Health Service Hospital at Lexington, Kentucky, for the cure of Drug addiction were under twenty-one years of age. Today, eighteen per cent are under twenty-one years of age. Most of these are the juvenile delinquent type, the High School student being the exception. These young people associating with criminals, begin to smoke Marijuana and then graduate to Heroin. Money to purchase Narcotics necessary to maintain addiction is usually obtained through criminal activities. Traffickers sensing the rise

of juvenile delinquency have turned to the juvenile delinquents as a source for victims.

Through the combined efforts of local and Federal law enforcement officials, substantial progress has been made against this corruption. In March, 1951, the Mayor and the Board of Estimates allocated Ten Thousand Dollars to the State's Attorney's Office to be used in the fight against narcotic traffic.

For the first time a Narcotics Squad has been established within the Police Department to concentrate on Narcotics violators. This Police detail now permits local agents of the Federal Bureau of Narcotics to concentrate their major efforts on traffickers. These agencies are waging a successful war against illicit dealers. Investigations take them into the underworld, the opium smokers den, the sordid and forbidden haunts of the drug addict and the office of the Doctor who has prostituted his profession by issuing illegal prescriptions for drugs. These officers are especially trained. They deal with informers and addicts. They have become experts in searching for drugs cleverly concealed in the walls of houses, furniture, hollow heels of shoes and in numerous other places known only to the wily and crafty, schooled in the ways of the criminal.

Criminals engaged in illicit Narcotic Drug traffic are desperate characters. The lives of officials are always in danger while taking indescribable risks in defense of society against the onslaught of this criminal conspiracy. The concerted efforts of authoritative agencies supplied with money from the State's Attorney's office have brought about excellent results in combatting this traffic. From January until September of 1950, only forty-eight narcotics cases were prosecuted in the Criminal Courts of Baltimore with sentences ranging from sixty days to two years. For the same period this vear, one hundred and thirty-five cases have been prosecuted in the same Courts. A breakdown of these cases discloses that eighty-five defendants were colored, thirty-two were white: ninety-eight were males and nineteen were females. Nine cases were under twenty-one years of age. Sentences have ranged from three months in jail to ten years in the Maryland Penitentiary. This breakdown indicates that drug addiction is not too prevalent among those under twenty-one years of age and I think should eradicate any foundation for hysteria.

Narcotics have become more difficult to obtain in Baltimore City. The price of these illicit drugs have been tripled. Many known peddlers are no longer operating here and have moved to other localities, principally Washington. Baltimore City has never been a source of supply but has been and is now a "victim city" between New York and Washington. I do not want to convey the impression that we are not still confronted with a serious situation worthy of our best efforts. Pressure should and will be continued against these traffickers.

One of the principle reasons for Narcotics traffic and addiction having flourished was the fact that peddlers were not severely dealt with by the Courts. It became apparent that little could be accomplished without the support of the Judiciary. Penalties for violation of the Narcotics laws had to be increased so as to furnish the Courts with a real weapon against the peddlers. Accordingly, the Legislature in its last session responded by fixing the penalty for second offenders at not more than two thousand dollars and imprisonment for not less than five years nor more than ten years; and the third offenders a fine of not more than three thousand dollars and imprisonment for not less than ten years nor more than twenty years. Legislation was also enacted making it a felony to sell and dispose of narcotics to minors and fix the punishment by imprisonment for a term of not less than five years and not more than twenty years.

Furthermore, the Legislature granted the State the right to seize all vehicles used in the transportation and concealment of narcotics. Since the time these statutes were enacted in

the Spring of this year (1951) a number of automobiles used in the transportation of drugs have been confiscated; heavy penalties have been imposed against second offenders and defendants convicted of selling drugs to minors have been punished severely. Vigorous prosecution and longer prison terms of the drug peddler will not fully solve the problems. The addicts and users themselves must be given special attention.

It is well established that drug addiction must be considered a communicable disease. Like smallpox, drug addiction should be cared for by local Public Health authorities. The addict must be taken out of circulation until cured. Cases in our Courts clearly demonstrate that addicts are usually incapable of following legitimate occupations. They will engage in criminal activities; particularly robbery, burglary and prostitution, in order to secure money to purchase narcotics. They spread physical destruction and moral degredation in their wake and are a menace to the community.

Local and State Governments should assume the responsibility of providing hospitalization for these unfortunates. The establishment of control wards in City and State hospitals ought not to be too difficult. The medical and psychiatric aspect of the drug problem deserves the best efforts of the medical profession and our law-making bodies. It is both a law enforcement problem and a medical problem. To exert efforts on the law enforcement aspect while neglecting the medical aspect of the matter will accomplish little.

I am happy to observe that Baltimore City Administration is now taking definite steps to provide control clinics for the treatment and cure of drug addicts. Thus when peddlers and addicts are removed from our streets, a source contagion is eliminated and the general crime situation alleviated as well.

Symposium continued in next issue

Component Medical Societies

BALTIMORE CITY MEDICAL SOCIETY

1211 Cathedral Street, Baltimore, Maryland

SAMUEL MCLANAHAN, M.D., *President* EDWARD F. COTTER, M.D., *Secretary*

J. ALBERT CHATARD, M.D., *Treasurer*

JOINT MEETING WITH THE SECTION ON SURGERY

I. RIDGEWAY TRIMBLE, M.D., *Chairman* E. RODERICK SHIPLEY, M.D., *Secretary*

Friday, February 15, 1952, 8:30 p.m.

SYMPOSIUM ON THE USE AND MISUSE OF BLOOD TRANSFUSION IN SURGERY

The names of the speakers will be announced.—*See page 33.*

Meetings

All these meetings will be held at 1211 Cathedral Street unless otherwise stated.

SECTION ON ANESTHESIA

LEONARD J. ABRAMOVITZ, M.D., *Chairman* OTTO C. PHILLIPS, M.D., *Secretary*

Monday, February 4, 1952, 8:30 p.m.

Treatment of Acute Clinical Emergencies. DONALD H. STUBBS, M.D., Chief of Anesthesiology, The Doctor's Hospital, Washington, D. C.; Clinical Professor of Anesthesiology, The George Washington University School of Medicine, Washington, D. C.; President of the Southern Society of Anesthesiologists. (By invitation.)

OPHTHALMOLOGICAL SECTION

ABRAHAM KREMEN, M.D., *Chairman* ANGUS L. MACLEAN, M.D., *Secretary*

JOINT MEETING WITH THE OPHTHALMOLOGICAL SECTION OF THE DISTRICT OF COLUMBIA MEDICAL SOCIETY

Tuesday, February 5, 1952

Dinner 6:30 p.m. *Scientific Meeting 8:00 p.m.*

Kennedy-Warren Hotel, 3133 Connecticut Avenue, N.W., Washington, D. C.

Subject to be announced. ALSTON CALLAHAN, M.D., Professor of Ophthalmology, Medical College of Alabama, Birmingham, Alabama.

WOMAN'S AUXILIARY TO THE BALTIMORE CITY MEDICAL SOCIETY

1211 Cathedral Street, Baltimore

MRS. H. HANFORD HOPKINS, *President* MRS. MARIUS P. JOHNSON, *Secretary*

MRS. HARRY C. BOWIE, *Treasurer*

Wednesday, February 6, 1952, 11:00 a.m.

Program to be announced.

NEUROPSYCHIATRIC SECTION

SAMUEL NOVEY, M.D., *Chairman*

JOINT MEETING WITH THE BALTIMORE PSYCHOANALYTIC SOCIETY

Thursday, February 14, 1952, 8:30 p.m.

Aesthetics as a Field for Psychoanalysis. MARK KANZER, M.D., New York City. (By invitation.)

THE OBSTETRICAL AND GYNECOLOGICAL SOCIETY OF MARYLAND

EMIL NOVAK, M.D., *President* W. DRUMMOND EATON, M.D., *Secretary*

Thursday, February 28, 1952
Hotel Stafford
Dinner 6:30 p.m.

Program to be announced.

PATHOLOGY SECTION

WILLIAM V. LOVITT, JR., M.D., *Secretary*

Monday, February 18, 1952, 7:30 p.m.

Program and place of meeting to be announced.

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

RICHARD W. TELINDE, M.D., *Chairman* BEVERLEY C. COMPTON, M.D., *Secretary*

Thursday, February 21, 1952
5:00 to 6:00 p.m.

MATERNAL MORTALITY MEETING

Thursday, February 28, 1952, 4:00 p.m.

Joint Committee on Maternal Mortality of the Baltimore City Medical Society and the Baltimore City Health Department.

UROLOGY SECTION

The Officers and members of the Section on Urology have proposed discontinuance of meetings for the time being.

CHARLES COUNTY

J. PARRAN JARBOE, M.D.

Resident Physician Selected for the Physicians' Memorial Hospital

A resident physician, Dr. Mary C. T. Mullan, has been selected by the Charles County Medical Society, to serve in the 40 bed Physicians' Memorial Hospital in La Plata. This is the first and only hospital in Southern Maryland to employ a full-time resident physician and this should be the solution to many emergency medical and surgical problems arising at the hospital.

Selection of the resident physician was made by the Charles County Medical Society from a list of 74 applicants. Each applicant was considered carefully and many were interviewed personally. The final approval was made by the Executive Board of the Physicians' Memorial Hospital and the Board of County Commissioners of Charles County. The position of resident physician was made possible by a special act of the Maryland Legislature enacted in March 1951, which authorized an additional tax levy to cover the salary and expenses needed to procure the services of a full-time resident physician. There has been dire need for such a physician for many years. The recent increase in the number of major operations, obstetrical deliveries, and rapid turn over of medical patients plus the increasing numbers of emergency cases has made the need a desperate one.

Dr. Mary C. T. Mullan, the new resident physician, was born in Northern Ireland, and was graduated in December 1947 from the Queen's University, Belfast—with the Bachelor of Medicine, Surgery, and the Art of Obstetrics Degrees. She has served in the Londonderry and Mid-Ulster Hospitals as House Physician and also has done general practice in Northern Ireland. She is a member of the British Medical Association and is registered to practice medicine in Great Britain and Ireland. Dr. Mullan served a general internship at the Holy Name Hospital, Teaneck, N. J., from October 1950, to October 1, 1951. She arrived at the Physicians' Memorial Hospital on October 8, and began her duties as the first resident physician.

In a short period of only two months, Dr. Mullan has proved that a resident physician is an irreplaceable asset to a small hospital. Her duties have been general in nature; but she has become invaluable to the surgeons and general practitioners and patients alike, and now the question arises: How did the hospital operate before a resident physician was obtained?

PRINCE GEORGE'S COUNTY

SAMUEL J. M. SUGAR, M.D.

The monthly program of Prince George's County Medical Society for January 1952 will include:

1. A panel discussion of the Harrison Act and narcotic addiction. Members of the panel will be made up of members of the Treasury Department and two physicians who have had experience with drug addiction at Lexington, Kentucky.
2. Annual election of officers was held December 4, 1951. Results will be published in the next issue of the JOURNAL.
3. Results of the Diabetes Detection Drive were announced at a recent meeting. 482 urine tests were done. Of these, two were positive and six were questionable.

TALBOT COUNTY MEDICAL SOCIETY

The Easton Star—Democrat newspaper of Easton, Maryland, stated:

Talbot Medical Society Honors Dr. Wm. S. Seymour. Engraved silver tray commemorates 55 years of practice in County. "Presented to Dr. William S. Seymour July 18, 1951, by the Talbot County Medical Society in recognition of 55 years devoted to the practice of medicine." So reads the inscription on a silver tray presented to the man whom Dr. Shepherd Krech, president of the Talbot County Medical Society described as "the Society's most active member" at a testimonial dinner given in his honor in the Garden Room of Tidewater Inn on Wednesday evening.

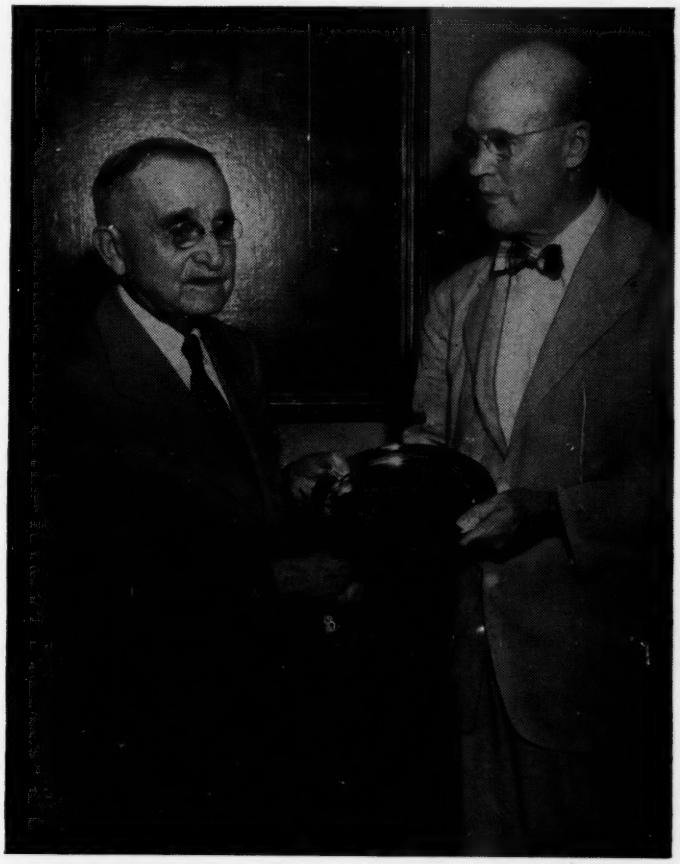
"It is with great pleasure that we can tonight pay tribute to one of our colleagues who has served his community so loyally for 55 years," Dr. William D. Noble, chairman of the committee on arrangements, said in making the presentation. This engraved silver tray, he said, is a symbol of the "de-

votion and esteem" of the members of the medical profession in Talbot County.

It was on June 25, 1895 that Dr. Seymour first opened his office in Trappe, upon graduation from the University of Maryland. Three other physicians were already practicing in this village of some 300 persons, but the number is not as disproportionate as it may seem by modern standards. In those days the horse and buggy was the only mode of transportation. Roads were mostly "mud and dirt." So a doctor with a rural practice could see but very few patients each day. Today, it is not unusual for a physician to make 20 home calls in a single day.

Dr. Seymour says it was between 1915 and 1918 that the county began to get roads which were good enough to warrant use of an automobile and even then, shell road surfaces were likely to cut tires so you had to continue on as best you could. He recalls his first automobile was a two cylinder Maxwell. "It was all right in summer, but I still had to rely on horse and buggy during winter months," he said.

When Dr. Seymour began practice there were no hospitals or nurses in the county. Deliveries had to be made by kerosene lamp, without assistance from anesthetist or nurse.



Dr. Guy Steele of Cambridge, who observed his 90th birthday on the 23 of June and who doesn't appear a day over 65, joined Dr. Seymour in reminiscing of the horse and buggy days of medicine in this section of the Shore.

Speakers were introduced by Dr. William T. Hammond who acted with Dr. Noble in arranging the testimonial.

The award is the first ever made by the Talbot County Medical Society for so long a tenure of service in the county and there is every indication Dr. Seymour will be on hand to mark further milestones as an active practitioner at suitable intervals for some time to come.

The Medical and Chirurgical Faculty extends its congratulations to Dr. Seymour.

WASHINGTON COUNTY MEDICAL SOCIETY HAGERSTOWN, MARYLAND

Beginning Sunday, September 30, the Washington County Medical Society will inaugurate a plan for the coverage of emergency cases in Hagerstown and Washington County.

While doctors here have always made a conscientious effort to take care of the emergency needs of the community, an occasional incident arises when it is difficult to obtain the family doctor or any doctor.

This unusual circumstance has usually occurred on a Thursday, Sunday or holiday.

While it is true that a majority of local physicians have no office hours in the afternoon and evening of these days, it is not true that many are away or out of town, a misconception that many people have had. They are, therefore, in many instances available for emergency work.

A substantial number on the Medical Society roster have volunteered to take care of the special emergency cases or sudden acute illness, when the family physician or his associate cannot be obtained on Thursday, Sunday, or a holiday.

Many cities of comparable size to Hagerstown or larger, have inaugurated similar systems for emergency coverage. By so doing, they have filled a need, which has given the public a better sense of security

The Medical Society, naturally, does not want the system to be abused. So it has set up the procedure for the care of emergency cases and sudden acute illness.

It emphasizes that the family physician or his associate should be called first on a Sunday, Thursday, or holiday. If he cannot be obtained, the call should be made to the Physicians Exchange, Hagerstown 2600, and a doctor will be secured.

Different doctors are serving their turn each week on a rotation basis.

The Medical Society reminded the public: First, call your own doctor. Do not call the Physicians Exchange, Hagerstown 2600, until you have made an effort to get your own doctor, or the doctor who is covering his work if he is engaged or away.—Courtesy of *The Daily Mail*, Friday, September 28, 1951.

THE BALTIMORE CITY MEDICAL SOCIETY

LOUIS A. M. KRAUSE, M.D.

The Baltimore City Medical Society, during the year 1951, has had a very successful year particularly from the point of view of their primary function and that is to promote the advance of medical science. I believe that one of the things that has contributed to the renewed enthusiasm at its meetings was the emphasis placed on a satisfying medical program.

The instructions to the Program Committee were: first, to furnish an attractive medical program; second, the absolute abandonment of refreshments at each meeting. It was felt that an adequate medical dish is the reason for the existence of the Society, and at no time should we resort to food as a means of maintaining or creating good attendance.

The Program Committee, under the able leadership of its Chairman, Dr. Wetherbee Fort, has accomplished outstanding results in the pursuit of the above policy, and the credit belongs entirely to this Committee.

I think it is apparent to all that our emphasis of such principles was entirely justified and I believe should be ever our inspiring motive.

MONTGOMERY COUNTY MEDICAL SOCIETY

KATHARINE A. CHAPMAN, M.D.

During the year 1951 the Montgomery County Medical Society has held meetings September to June on the third Tuesday of each month, each meeting preceded by a dinner served at Olney Inn, Olney, Maryland. At the annual meeting in March

the members of the Woman's Auxiliary were the guests of the Association.

Much time has been given during the year to the study of border-line medical practices such as naturopathy, podiatry and dianetics; also to revising the zoning ordinances so that doctors may have offices in Residential "C" areas (apartment houses) in which they do not reside.

To each member during the past year there has been sent a revised copy of the Constitution and By-Laws and a copy of Medical Directory which was compiled for distribution to police and fire departments, school nurses and clinics, drug stores, rescue squads, and to new residents through the Welcome Wagon, Inc.

The present membership of the Society is 213 of which 162 are active, 50 associate and 1 honorary. Nine of the active members have been elected as life members. Eight members are in active military service.

SPECIAL ANNOUNCEMENT

The program of the February 15th meeting of the Baltimore City Medical Society is as follows:

8:30 P.M.

The Cause and Prevention of Homologous Serum Jaundice. J. GARROTT ALLEN, M.D., Associate Professor of Surgery, University of Chicago School of Medicine, Chicago, Illinois. (*By Invitation.*)

9:15 P.M.

Untoward Reactions from Blood Transfusions. C. LOCKARD CONLEY, M.D., Associate Professor of Medicine, The Johns Hopkins University School of Medicine.

10:00 P.M.

Discussion period.

Library

THE LIBRARY—1930–1950

PAULINE DUFFIELD, *Librarian*

The library of the Medical and Chirurgical Faculty of the State of Maryland was organized in 1830. From its meager beginning and its wandering from home to home, it has survived to attain a proud place among the medical libraries of the United States.

The library has several endowments provided by members and their friends. They are the Finney, Stokes, Harlan, Baker, Barker, Ruhräh and Osler funds. These funds are set up to provide for the purchase of books and journals in the various special fields of interest of the donor. In 1892, the Faculty provided one half of its income for the library; in 1950, less than twenty per cent of the income was used for the support of the library; today, the library is striving to maintain the high standards set up by the physicians of this State.

In 1930, the library held its centennial, which was looked upon as one of the highlights of the Faculty. At this celebration, the late Marcia C. Noyes said, "But of all the activities of this old State Association—and they are varied—the library is the one of most permanent value. Its books are something concrete to show from generation to generation."

For the past twenty-one years, Dr. Andrew C. Gillis has served as Chairman of the Library Committee. During these years, he has given wise counseling to the library staff which has been greatly appreciated by all who have served under him. The position of Committee Chairman has been a most difficult one in view of the economic situation, the changes within the organization and World War II.

To mention a few of the changes that have taken place in the last twenty years would be to compare the size and growth of the library. In 1930, there were 37,481 volumes. Today, we have a total of 75,539 volumes and several thousand reprints which are available for use.

In 1934, a special tribute was paid to the memory of Dr. John Ruhräh, who had served as Chairman of the Library Committee and who also had held many positions in the Faculty. A memorial room was dedicated to house his collection of non-medical books. A proper and fitting bookplate was designed by the late Max Brödel. Dr. Ruhräh left his entire estate of over a hundred thousand dollars to eventually come to the library. The income is to be used to purchase books and journals in the fields of his special interests.

In 1936, the library was receiving 235 journals regularly. Nintety-one of these were gifts or exchanges with the transactions. In this same year, Dr. Stewart Paton donated to the library a very fine collection of eighteenth century rare books.

In 1941, Dr. Stewart Paton also gave the library a large collection of books on psychiatry. During this same year, the library also received several foreign journals from the William H. Welch estate to fill in our back sets.

A large collection of books was received from the Julius Friedenwald estate during the year of 1942.

A fine collection of great value in the field of medical history was given to the library by Dr. Walter R. Steiner in 1943. We are also future beneficiaries under his will.

In 1946, the death of Miss Marcia C. Noyes, who had served as librarian since 1896, was indeed a great loss to the library. The library had been her greatest interest for fifty years and the great collection she supervised is a memorial to her.

In 1948, through the efforts of Dr. Thomas S. Cullen and the Library Committee, the long-lost and, to our knowledge, the only copy of the 1835 Catalogue of the Library of the Medical and Chirurgical Faculty was returned to us from the Army Medical Library, where it had been a prized possession in their rare book collection before 1900.

The Eugene J. Leopold Collection, which was an oustanding collection of books on diabetes, was presented to the library by Mrs. Leopold.

In 1948, the rare book collection was enriched by the gifts of Drs. J. Albert Chatard and Ferdinand E. Chatard, IV. The gifts included *Liber Metricius de Pulsibus cum Commentarie Gentilis Fulginatis* by Aegidus Corboliensis (1484), *Incipit Excellentissimi Medici* by Petrus de Abano (1498) and *Aliquot Opuscula nunc Primum Venetorum Opera Inventa et Excusa* by Claudius Galen, (1550). We are indeed proud of these rare items.

The death of Dr. Harry Friedenwald in April, 1950, was a great loss to the Library and Finney Fund Committee on which he had served since 1896.

Through the courtesy of Dr. Beverley C. Compton, the library secured two large display cases in which we can now display some of the rare items. At the present time, we have on loan a stamp collection of Dr. Margaret Ballard. Also on display are several items from the Steiner Collection.

Today, the library receives regularly 320 journals and has added approximately 417 books this year. The book lists have appeared in the monthly Bulletin.

In August 1950, Mrs. Nellie N. Cowles bequeathed to the library one thousand dollars, the income to be used to purchase books on neurology in the name of Dr. Lewellys F. Barker.

The library staff will at any time try to help the members in any way possible, compiling bibliogråphies, checking references or any of the many other details they may require. It is the desire of the Library Committee and the library staff to serve the members, but to serve them we must know their needs. The library is only as far away as your telephone or mail box. We would like to remind the members outside of Baltimore City that the same service is offered to them if they will only make their needs known.

The library has been open three nights a week this year instead of the usual five. This has been, as far as we can tell, fairly satisfactory to everyone. However, if any member finds that the present hours are not to his convenience, we would appreciate his notifying the Chairman of the Library Committee.

The library has had great need of more space for several years. Earlier this year, it was necessary to move the material which was not indexed in medical literature to the basement. This allowed for the shelving of this year's journals and provided space for the next four years. However, the problem is far from being solved and the basement arrangement is entirely unsatisfactory.

The statistics show a gradual increase in the use of the library and its resources.

Circulation has increased slightly within the past three years. The figures show that 10,496 volumes were used in 1948, 11,497 in 1949, and 11,054 in 1950.

The library should be looked upon by all members with great satisfaction. It held and strengthened the Society for many years. Your choicest treasures are housed in the library, the old and new discoveries of science, the records of the past and the present are all gathered together. It is your library.

A FEW OF THE RECENT PUBLICATIONS BY FACULTY MEMBERS

Abeshouse, B. S.

Aneurysm of the renal artery: report of two cases and review of the literature. Urologic and Cutaneous Rev. 55: 451–463, Aug., 1951.

Diverticula of anterior urethra in the male: a report of four cases and a review of the literature. Urologic and Cutaneous Rev. 55: 690–707, Nov., 1951.

and Scherlis, I., Golden, M. and Rubin, M.

Aortography and renal arteriography following percutaneous retrograde catheterization of the femoral artery and aorta. Urologic and Cutaneous Rev. 55: 517–528, Sept., 1951.

Blair, E. and Brantigan, O. C.

Perforation of gastrojejunal ulcer following subtotal gastric resection for duodenal ulcer. Case report. Bull. of the School of Med., Univ. of Md. 36: 133–136, July, 1951.

Broyles, E. N.
The diagnosis and treatment of early malignant disease of the larynx. Southern M. Jr. 44: 692, Aug., 1951.

Brunst, V. V., Barnett, D. J., and Figge, F. H. J.
Reaction of tissues of amphibians after local roentgen irradiation. Amer. Jr. Roentgenol. 66: 420–434, Sept., 1951.

Bubert, H. M.
Penicillin in bronchial asthma. Bull. of the School of Med., Univ. of Md., 36: 115–118, July, 1951.

Curtis, R. M., Brewer, J. H. and Rose, I. A. (Jr.)
New technique for local treatment of burns. J. A. M. A. 147: 741–743, Oct. 20, 1951.

Decker, H. C., McDowell, F. W. and Trimble, I. R.
Pheochromocytoma, case report with discussion of differential diagnosis and surgical treatment. J. A. M. A. 147: 642–645, Oct. 13, 1951.

Feldman, M. and Weinburg, T.
Healing of peptic ulcer. Amer. Jr. Dig. Dis. 18: 295–296, Oct., 1951.

Fitzpatrick, V. DeP., Hunter, R. E. and Brambel, C. E.
The use of multiple intestinal absorbents as an adjunct in the management of nausea and vomiting in pregnancy. Amer. Jr. Dig. Dis. 18: 340–342, Sept., 1951.

Gann, E. and Hoffman, E.
Presacral neurofibroma. Amer. Jr. Surg. 82: 405–407, Sept., 1951.

Garlick, W. L., Barnett, D. J., Spencer, H. R., Sheppard, R. C. and Cunningham, R. M.
Clinico-pathologic conference. Bull. of the School of Med., Univ. of Md. 36: 137–140, July, 1951.

Goldstein, A. E.
Polycystic renal disease with particular reference to author's surgical procedure. Jr. of Urol. 66: 163–172, Aug., 1951.

Gray, D. B., Mansberger, A. R. (Jr.) and Yeager, G. H.
The fate of buried full-thickness skin. Ann. Surg. 134: 205–209, Aug., 1951.

Hahn, R. D., Lewis, B. I., Wiggal, R. H., and Cross, E. S. (Jr.)
The treatment of neurosyphilis with penicillin and with penicillin plus malaria. Amer. Jr. Syphil. 35: 433–470, Sept., 1951.

Kern, M.
Amputations of lower extremities in the aged. Amer. Jr. Surg. 82: 479–484, Oct., 1951.

Koontz, A. R.
Inguinal hernias, some causes of recurrence. Amer. Jr. Surg. 82: 474–478, Oct., 1951.

Lewison, E. F. and Chambers, R. G.
Clinical significance of nipple discharge. J. A. M. A. 147: 295–299, Sept. 22, 1951.

Macht, D. I.
New studies experimental and clinical of pemphigus. Urologic and Cutaneous Rev. 55: 550–559, Sept., 1951.

Mandy, T. E., Christhilf, S. M. (Jr.), Mandy, A. J. and Siegel, I. A.
Evaluation of the Rucher method of episiotomy repair as to perineal pain. Amer. Jr. Surg. 82: 251–255, Aug., 1951.

and Scher, E., Farkas, R. and Mandy, A. J.
The psychic aspects of sterility and abortion. Southern M. Jr. 44: 1054–1059, Nov., 1951.

Mansberger, A. R. (Jr.), Jennings, E. R., Smith, E. P. (Jr.) and Yeager, G. H.
A new type pull-out wire for tendon surgery: preliminary report. Bull. of the School of Med., Univ. of Md. 36: 119–121, July, 1951.

Mansfield, W. K.
Urinary tract injuries in gynecological surgery. Urologic and Cutaneous Rev. 55: 626–628, Sept., 1951.

Morrison, S. and Feldman, M.
The healing of a primary duodenal ulcer with the later development of a gastric ulcer. Amer. Jr. Dig. Dis. 18: 296–298, Oct., 1951.

Mosberg, W. H. (Jr.) and McAlpine, J. D.
Torulosis of the central nervous system: biochemical behavior of the causative organism. Bull. of the School of Med., Univ. of Md. 36: 122–125, July, 1951.

Rademaker, L. and Royer, E. L.
Volvulus of the colon. Southern M. Jr. 44: 1005–1008, Nov., 1951.

Ravitch, M. M.
Diagnosis and treatment of carcinoma of rectosigmoid and anorectal areas. Amer. Surgeon 17: 811–824, Sept., 1951.
Radical treatment of massive mixed angiomas

(hemolymph angiomas) in infants and children. Ann. Surg. 134: 228–243, Aug., 1951.

Robinson, H. M. and Robinson, H. M. (Jr.)
Terramycin in the treatment of syphilis. Amer. Jr. Syphil. 35: 479–481, Sept., 1951.

Robinson, R. C. V. and Galen, W. P.
Aureomycin in the treatment of gonorrhea in the male: further observations. Amer. Jr. Syphil. 35: 488–489, Sept., 1951.

Rubin, S. W. and Nagel, H.
Nocturia in the Aged. J. A. M. A. 147: 840–841, Oct. 27, 1951.

Sacks, M. S., Bradford, G. T. and Spurling, C. L.
Aplastic anemia complicating streptomycin treatment of pulmonary tuberculosis. Report of a case, with recovery. J. A. M. A. 147: 308–311, Sept. 22, 1951.

Schoenbach, E. B., Miller, J. M., Ginsberg, M. and Long, P. H.
Systemic blastomycosis treated with stilbanidine. A preliminary report. J. A. M. A. 146: 1317–1318, Aug. 4, 1951.

Sherman, J. and Gay, L. M.
Survey of ragweed pollination in Maryland for 1949. Southern M. Jr. 44: 749–754, Aug., 1951.

Siegel, I. A. and McNally, H. B.
Primary breech presentation and external cephalic version. The management of 308 primary breech presentations. Southern M. Jr. 44: 942–950, Oct., 1951.

Stone, H. B., Curtis, R. M. and Brewer, J. H.
Can resistance to cancer be induced? Ann. Surg. 134: 519–528, Sept., 1951.

Stokes, J. (Jr.), Farquhar, J. A., Drake, M. E., Capps, R. B., and Ward, C. S. (Jr.)
Infectious hepatitis. Length of protection by immune serum globulin (gamma globulin) during epidemics. J. A. M. A. 147: 714–719, Oct. 20, 1951.

EUROPEAN MEETINGS 1952

July 8 to 11, British Congress of Obstetrics and Gynecology, Leeds, England.
July 8 to 13, Commonwealth and Empire Health and Tuberculosis Conference, London, England.
September 8 to 13, International Congress on Neuropathology, Rome, Italy.
July 14 to 19, International Congress of Physical Medicine, London, England.
July 19 to 25, International Congress of Radiology, Copenhagen, Denmark.

Board of Medical Examiners

THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF MARYLAND

Faculty Annex, 1215 Cathedral Street

LEWIS P. GUNDRY, M.D.

Secretary

In order to acquaint the membership with the responsibilities and activities of the Board of Medical Examiners, it is proposed to submit a report at infrequent intervals. The following was received from Lewis P. Gundry, M.D., Secretary of the Board:

The Medical and Chirurgical Faculty or Medical Society of the State of Maryland was established by an act of the Legislature in the year 1799. This Act also provided that there be appointed a Board of Examiners consisting of twelve persons—seven from the Western and five from the Eastern Shore. As presently constituted, the BOARD was established by an act of the Legislature in 1892. It is known as the Board of Medical Examiners of the State of Maryland and is composed of eight members. Board members are elected by the Medical and Chirurgical Faculty at their annual meeting in April; two being elected every year for a term of four years. Since each physician on the Board is selected and elected by the Medical Society he is not a political appointee and is in no way hampered by political pressures.

To conduct their official business the Board holds meetings at regular intervals. At the annual meeting in June a president, vice-president and a secretary-treasurer are elected for a term of one year. These three members constitute the executive committee of the Board. One of the most important functions of the Board is to give written examinations to eligible candidates. Each member of the Board is designated to give and mark examinations in one subject. At present, examinations are given in anatomy, physiology, chemistry, surgery, practice of medicine, therapeutics and pharmacology, obstetrics, and pathology.

It is the responsibility of the Board under the Medical Practice Act to issue licenses to those who qualify after written examination and to those who present proper credentials for license by reciprocity from another state, or endorsement of a National Board certificate. The Board may revoke any license which it has issued for a number of causes which are listed in the Medical Practice Act. Statistics relating to licensure in this and other states are published each year in the State Board number of the Journal of the American Medical Association.

The Board of Medical Examiners of the State of Maryland is a member of the Federation of State Medical Boards of the United States. The Board sends one or more delegates each year to the Annual Congress on Medical Education and Licensure held in Chicago by the Federation of State Board and the Council on Medical Education and Hospitals of the American Medical Association. At this meeting problems of mutual interest concerning licensure and medical education are discussed.

Health Departments

GREETINGS FROM THE STATE DEPARTMENT OF HEALTH

The State Department of Health extends its cordial welcome to this new publication of the Faculty. The MARYLAND STATE MEDICAL JOURNAL should serve a most useful purpose in keeping members informed of current medical happenings in the State and in making possible complete coordination between the work of the medical profession and that of those public agencies whose functions involve medical considerations.

It is the purpose of the State Department of Health to make use of this new organ to familiarize the members of the profession with changes in its procedure and with current happenings in the field of public health.

It is our earnest hope that the members of the Medical and Chirurgical Faculty will use its pages to express their opinions about public medical questions and to register any criticisms or complaints that they may have of our service.

R. H. Riley

Director

BALTIMORE CITY HEALTH DEPARTMENT

It is with much satisfaction that the Baltimore City Health Department sends this greeting to the Medical and Chirurgical Faculty of Maryland on the occasion of the inauguration of the MARYLAND STATE MEDICAL JOURNAL. The Faculty and the Department have been teammates in working for the best interests of the people of Baltimore for many decades, for both had their start in the 1790's and each has included members of the other in its ranks from the beginning.

In the November, 1931 issue of *Baltimore Health News*, after referring to the sterling work of Dr. C. Hampson Jones, then Commissioner of Health of Baltimore, and of the martyr city bacteriologist, Dr. William Royal Stokes, and to the changes and developments in modern public health, I wrote

> Leadership in health promotion is the function of a health department. It should organize a far-reaching program. No health department can do its job along modern lines, however, without the active support of the medical profession. We need this support and expect to receive it. Such work as the eradication of diphtheria, the reduction of the veneral diseases and the adequate care of expectant mothers and of young children must rest largely in the hands of the practicing physicians. We can do much as a health department to teach the public to seek such "keep-well" services.
>
> Only with the united backing of the physicians and the individual citizens can the Baltimore Health Department accomplish its true purpose as the standard-bearer of better city health.

During the past twenty years many changes have come into the public health picture in Baltimore and elsewhere. It is the hope of the City Health Department that during these years it has merited the good will and backing of the many physicians who make up our profession in the city. Very real efforts have been made to bring about this spirit of teamwork and they will continue to be made.

Together, and hand in hand with our sister Department which serves the counties of Maryland, we may go forward confidently to face the health and medical and social challenges of today and tomorrow; such challenges as a better organization of the medical care services for all the people, geriatrics and its many complex implications, improved housing with a resulting better health and life for the less privileged, the teen-age use of narcotics, fluoridation of the city water supply and the eventual control of the overpollution of the city's atmosphere.

Huntington Williams, M.D.

Commissioner of Health

Hospital News

HOSPITAL AND HEALTH FACILITY CONSTRUCTION UNDER THE MARYLAND HOSPITAL SURVEY AND PLAN

HERBERT G. FRITZ

Chief, Division of Hospital Services State Department of Health

Hospital and Public Health facility construction in Maryland under the Federal Hospital Survey and Construction Act for the first five years (1948–1952) of the program will amount to $17,126,471.00 when projects now in progress or approved for construction are completed. This includes 25 projects. The Federal share of the above cost is $5,197,836.06

The 25 projects include the following:

(1) New Garrett County Memorial Hospital at Oakland, Garrett County.

(2) New Calvert County Hospital, Prince Frederick, Calvert County, replacing old hospital which was unacceptable.

(3) Addition to the Washington County Hospital at Hagerstown, Washington County.

(4) Addition to the University of Maryland Hospital including a psychiatric unit and general hospital beds in Baltimore.

(5) Addition to the Prince George's General Hospital at Cheverly, Prince George's County.

(6) Addition to the Frederick Memorial Hospital at Frederick, Frederick County.

(7) Addition to the Peninsula General Hospital at Salisbury, Wicomico County.

(8) Addition to the Memorial Hospital at Cumberland, Allegany County.

(9) New tuberculosis hospital for the Associated Jewish Charities of Baltimore.

(10) New addition to the tuberculosis unit of the Baltimore City Hospitals, Baltimore.

(11) New Christ Child Convalescent Hospital (chronic disease hospital for children), at Rockville, Montgomery County, replacing an unacceptable facility.

(12) Remodeling the State Bacteriology Laboratory Building in Baltimore.

(13) New Health and Welfare Building at Annapolis, Anne Arundel County.

(14) New Auxiliary Health Center at Havre de Grace, Harford County.

(15) New Health Center at Westminster, Carroll County.

(16) Equipment for the Southern Health District Building at Baltimore.

(17) New Health Center at Denton, Caroline County.

(18) New Health Center at Leonardtown, St. Mary's County.

(19) New boiler plant at Annapolis Emergency Hospital Association, Annapolis, Anne Arundel County, where a large wing will be added to the hospital.

(20) Addition to the Kent & Queen Anne Hospital at Chestertown, Kent County.

(21) Addition to the Easton Memorial Hospital at Easton, Talbot County.

(22) Addition to the Annapolis Emergency Hospital at Annapolis, Anne Arundel County.

(23) New power plant for the Franklin Square Hospital in Baltimore City, where a large addition is planned.

(24) New Health Center at Chestertown, Kent County.

(25) Equipment for the Southeastern Health District Building in Baltimore.

The program operates under the Maryland Hospital Survey and Plan. The original survey was made under the Maryland State Planning Commission.

Applications may be accepted only from governmental bodies or non-profit corporations. Projects are approved in accordance with a priority schedule which is a part of the Maryland Hospital Survey and Plan. This plan and the priority schedule are revised annually to account for changes such as new construction, population shifts and utilization of existing facilities. Emphasis is placed on locating new or additional facilities at points of greatest need, the need being determined by the relationship of existing facilities to the determined need and current utilization of existing facilities.

Priority between various categories of facilities such as tuberculosis, chronic disease, mental and general hospitals is based on the degree to which the need is met in each category. As a result of the application of these factors construction of general hospital facilities has been largely in rural areas. At the same time there has been construction in each of the categories. If the program is continued on this basis, ultimately, there will be a balance between the several categories, the limiting factor being the availability of matching funds. Ten per cent of the Federal allotment is made available for public health center construction.

Considerable use is made of the State Plan by groups considering hospital construction whether or not they intend to apply for Federal assistance. It is used as a guide in determining the need for a hospital construction program in their community and the size to which it should be planned.

Since priority is granted on the basis of percentage of met need and utilization of existing facilities it is extremely unlikely that a community or group having funds available for the construction of a hospital will be encouraged or assisted financially with the project if the need is not apparent and efficient utilization is not being made of the existing facilities in the community. The only exception to this would come about if the existing facility is unsafe and not considered acceptable.

The program has brought into existence consulting services which had not previously been available to sponsors of hospital projects or the architects whom they employ. Technical consulting services are available at the State level and through the State agency at the Federal level. The services of personnel of the State Department of Health, Division of Hospital Services, available for consultation includes an architectural engineer and an architect, a hospital administrator, a consultant dietitian, nurses with degrees and broad experience in hospital administration and public health services. Their services are available for preliminary discussions and throughout the development, construction and equipping of the project.

The following account of the procedure of a project illustrates the working of the program, including the use of the services available:

The Board of a hospital, either existing or proposed, will usually start the construction program by deciding to investigate the need for new or additional facilities in the community or area. The first resource is the State Plan, copies of which are available to them. The Plan shows the number of hospital beds available, the percentage of occupancy and the priority status of the area. With this information as a point of departure a study of local conditions can be initiated.

Sponsors are advised to employ a hospital consultant to assist with a detailed study of the community needs. When such consultant is employed, the services and files of the Division of Hospital Services are made available to him.

As soon as an architect is commissioned for the project he is advised of the availability of services in the Division of Hospital Services. He is supplied with materials prepared at both the State and Federal levels. The facility must comply with minimum standards established at the Federal and State levels, however, the architect is not otherwise bound insofar as esthetics and design are concerned.

When the size of the facility needed is determined the architect as a rule will prepare schematic, single line floor plans. These may be submitted to the Division of Hospital Services for review, either before or after review by the sponsoring group. The drawings are reviewed for inclusiveness of facilities, functional layout, space assignment and compliance with minimum standards. After conferences intended to arrive at concurrence between the Division of Hospital Services, the architect and the sponsors, revised schematic drawings are prepared by the architect incorporating the changes agreed upon. These revised schematic drawings are then submitted to the U. S. Public Health Services, Division of Hospital Facilities, for review and approval. Should the Federal reviewing agency make recommendations

these are transmitted to the architect and the Board. When Federal approval has been obtained, the architect and sponsors are notified.

The architect then proceeds with preliminary drawings showing more detail, including built-in equipment. These drawings are processed in the same manner as the schematic drawings. When necessary approvals have been obtained he proceeds with the development of working or contract drawings and specifications. These are subject to the same reviews and approvals.

This procedure insures the inclusion of necessary facilities, proper functional relationship of departments and proper space allotments.

Contracts must be on a competitive, lump sum basis. Bidders must give assurance that they will pay prevailing wages approved by the U. S. Department of Labor.

During construction inspections are made by State and Federal representatives to ascertain that the project is being built in conformity with specifications.

Upon completion and settlement of obligations Federal participation and authority ceases. The only continuing Federal right is that of recovery if the facility ceases to be used as a public or non-profit hospital within a period of 20 years.

FINANCES

The current rate of Federal participation is 33⅓%. This has fluctuated from 33⅓% to 44% and back to 33⅓% as the amount of Federal funds have been changed by Congress. Federal funds are applicable to construction and equipment costs on hospital projects. On projects for public health facilities the cost of the site is included.

Sponsors are required to have in cash or liquid assets one-third of their share of the estimated cost at the time of filing the first part of their application. Before the project is finally approved for contract, the full amount of the sponsor's share must be available. Borrowed funds are limited to one-third of the sponsor's share. Federal funds are paid to the sponsors on the basis of physical completion.

Sponsors are required to estimate the amount of deficit which might be expected during the first two years of operation and show the source of funds for underwriting the calculated deficit.

These regulations give assurance that the project will be completed and deficits for the first two years of operation will be met.

The program was originally established for a five year period ending in 1951 but Congress has extended it to 1956.

The amount of construction under the program is limited by the amount of Federal funds available. Construction within this limitation cannot provide sufficient hospital facilities to meet the need for additional facilities in Maryland. If the need is to be met much construction will have to proceed without benefit of Federal funds.

The program has apparently met with general approval since all funds available have been used. It is felt that under the program hospital construction has proceeded in an orderly manner at points of determined need.

PRESENT STATUS OF STUDY OF PREMATURES

PAUL HARPER, M.D.

In the August issue of the News Letter of the Medical and Chirurgical Faculty of the State of Maryland appeared an announcement that the Faculty had endorsed a statewide Study of Prematures. This is an important study being undertaken by the Division of Maternal and Child Health of the Johns Hopkins University. The full cooperation of all physicians in the State is urged. By the time this article appears in print a pilot study should have been completed and the study itself should be under way in all hospitals in the State with maternity services. Also by this time most physicians in the state should have received a letter explaining various features of the study.

The need for the study arises from the fact that prematurity is steadily becoming of relatively greater

importance as a cause of infant death. This is not because of an increase in prematurity but because of the rapid decline of deaths due to infection. The study has two aims, first, to evaluate the hospital care rendered prematures in terms of survival, and, second, to determine how many of those prematures who do survive develop normally and in what ways the other survivors are handicapped. For the purposes of the study a premature infant is being defined as any live born infant whose weight at birth is 2500 grams (5 pounds, 8 ounces) or less; and all such infants born in Maryland in 1952 are to be included. Although this means some 3000 prematures, the average will be only about two per physician.

The evaluation of hospital care will be undertaken by means of comparing the neonatal mortality of prematures cared for in different groups of hospitals. A survey of the arrangements and practices for the care of prematures in the hospitals is now about half complete. In addition, all hospitals are cooperating in furnishing information about the prematures on such items as prenatal care, complications of pregnancy, data about labor and delivery and the care of the premature after birth. It is possible that this study will suggest that more attention should be given to the prevention of prematurity by such measures as early hospitalization of mothers with complications, rather than putting the major emphasis on the treating of prematures after they arrive.

The follow-up of those prematures who survive their first month will also be conducted on a statewide basis. All prematures born in Maryland to residents of Maryland will be followed throughout their first year of life. The object will be to obtain information concerning the developmental level of each premature at several points during his first year.

In addition to this, there will be in Baltimore a relatively small group of prematures and a comparable group of full-term infants serving as controls who will be given a Gesell Developmental Examination at forty weeks of age. Although the Gesell Developmental Examination is to be done routinely only on the limited group in Baltimore, such an examination is being offered as a matter of courtesy to all physicians throughout the State for any of their prematures about which they may be particularly concerned. Such examinations will be for diagnosis only. A report of findings will be furnished to the referring physicians and the infant's mother will be returned to him for all advice. Present plans also include following this limited group in Baltimore beyond their first year, possibly well into their school years.

The Study Staff plans to provide information concerning the Study from time to time so that the physician will be kept up to date on its progress

Insurance

BLUE SHIELD PROGRESSES

Just a year ago, November 1, 1950, Dr. Hugh J. Jewett, President of the Board of Trustees of Maryland Medical Service, Inc., presented Maryland's first Blue Shield membership certificate to Miss Ann Charshee of Parke, Davis & Company's Baltimore office. Only six days later the first patient, Miss Dorlene Shantz of Hagerstown, went to a hospital.

Today there are more than 55,000 members of the new Plan.

In addition, slightly over 100,000 Marylanders are now protected (since September 1st) under a special contract with the Bethlehem Steel Company which provides surgical benefits only. National Blue Shield contracts with various steel companies now protect more than 1,500,000 persons.

During the first nine months of 1951, more than 4,000 persons received Blue Shield benefits, totaling over $200,000.

Meanwhile, the list of Participating Physicians has grown from the original 1,400 to more than 1,550 and new Participating Agreements are being received each week.

Through the year, members of the Plan's Board of Trustees have held their regular monthly meetings as well as several special meetings. Members of this Board, headed by Dr. Jewett are: Dr. Warde B. Allan, Vice-President; Mr. Donald H. Sherwood, Secretary; Mr. Robert O. Bonnell, Treasurer; Mr. Hilary W. Gans, Dr. Frank F. Lusby, Dr. J. Morris Reese, Dr. Benjamin S. Rich, Dr. Alexander J. Schaffer, Dr. I. Ridgeway Trimble, Dr. Henry F. Ullrich and Mr. Harvey H. Weiss.

The Medical Relations Committee and the Reference and Appeals Committee, the members of which are appointed by the Council of the Medical and Chirurgical Faculty of the State of Maryland, have been active in carrying out their functions.

The Medical Relations Committee consists of the eight medical members of the Board of Trustees in addition to Dr. John W. Parsons, Dr. S. Edwin Muller and Dr. J. H. Mason Knox, III.

The Reference and Appeals Committee consists of Dr. Parsons, Dr. Knox and Dr. Muller, also Dr. Thurston R. Adams, Dr. John B. DeHoff, Dr. Lester T. Chance, Dr. Donald Hooker, Dr. E. T. Lisansky and Dr. E. Roderick Shipley.

The total national Blue Shield membership now totals more than 21 million persons. As of June 30, 1951, the Michigan Blue Shield Plan led all the others with more than 2,280,000 subscribers followed by New York with an enrollment of over 2,200,000.

EDITORIAL BOARD ANNOUNCEMENT

The following counties have submitted candidates for nomination to the Editorial Board: Allegany-Garrett, Cecil, St. Mary's and Washington. Every County Medical Society has been requested to submit suggestions for these positions on the Board.

The Auxiliaries

Woman's Auxiliary to the Medical and Chirurgical Faculty

NEWS OF COMPONENT AUXILIARIES

MRS. LEWIS P. GUNDRY, *Corresponding Secretary*

Mrs. George Urban, President of the BALTIMORE COUNTY AUXILIARY, reports a busy year. Tea was served on two occasions, by Auxiliary members, for the doctors attending lectures on Atomic Defense. In March, a benefit dance, held to finance Maryland's first Nursing Scholarship, was a great success. The recipient of the scholarship, Miss Patricia Leffell, of White Hall, Maryland, is now in training at the University Hospital. Baltimore County plans to make this a yearly project.

Mrs. Urban also reports the work done at the Timonium Fair an outstanding success. During the week of the Fair, over 14,000 pieces of literature were distributed; in addition, the Auxiliary sponsored a health booth. Three films were shown, one on narcotics addiction, another on the use of animals in medical research and a third showing the disadvantages of Socialized Medicine. Baltimore County is an inspiration to us all.

BALTIMORE CITY AUXILIARY has an important project for the year, namely, "To Educate Ourselves On Health Problems." Mrs. H. Hanford Hopkins, President of the Auxiliary, reports that at the October meeting, Dr. L. B. Davis gave an interesting talk on "Drug Addiction in the Public Schools." In December, Dr. John L. Krantz addressed the members—his subject, "Physicians, Potions, People and their Purses." He discussed the improper use of antibiotics, diets, drugs and patent medicines.

Mrs. James P. Kerr, President of MONTGOMERY COUNTY AUXILIARY, sends word that at their November meeting, Dr. Welte of Rock Hall, spoke on the subject of Tuberculosis. They, also, are planning to start a scholarship for the nurses and in addition are working to interest the schools in an Essay Contest on the outstanding success of American Medicine under our system of free competition.

PRINCE GEORGE'S COUNTY AUXILIARY' Mrs. Jack Sugar, President, is a third group sponsoring a nurse's scholarship for a three year period. During October the members of this Auxiliary donated blood to the Red Cross. Mrs. Sugar also reports a contribution of one hundred dollars to the Doctors Library, of the Prince George's General Hospital. Last year a donation of one hundred dollars was made to the County Health Drive.

Mrs. John H. Beachley, President of WASHINGTON COUNTY AUXILIARY, tells us that members have been most cooperative and generous in giving their time to help with the Tuberculosis Stamp Sale, the March of Dimes and the Red Cross Drive. They assumed the entire responsibility of staffing a Cancer Booth in a downtown store during the month of April, either serving personally or supplying a worker. Also, they have shipped to New York, for use overseas, a seventy-five pound box of drugs, a small quantity of supplies and medical instruments, A.M.A. Journals, as well as packs of transcripts of Medical Research Literature.

This month we have no report from Cecil, Dorchester and Frederick Counties, but hope to give you news of them in the next issue.

THE CHICAGO CONFERENCE

A worthwhile trip to Chicago was made by our President, Mrs. George H. Yeager, and the President-elect, Mrs. Charles H. Williams, to represent us at the November Conference of the Woman's Auxiliary to the A.M.A. They returned with a number of new ideas to further our program on Public Medical Education and Nurse Recruitment. For example, to increase interest in Nurse Recruitment, there is an excellent sound film, called "Girls in White," which can be obtained from the American Hospital Association, 18 East Division Street, Chicago 10, Illinois.

To combat apathy concerning Civil Defense in

Maryland, which is one of four target areas in the United States, the various Auxiliaries to the Medical Societies can do an important job. We are asked to urge immediate procurement of individual identification tags and blood typing in our communities.

Working details of conference suggestions will be relayed to each County Auxiliary through the appropriate state committee chairman.

OUR CONTRIBUTION TO THE CONFERENCE

Largely due to the success of Maryland's work last year for the use of animals in research, the National Auxiliary is planning to make Medical Research a permanent part of its regular program. Our Maryland Auxiliary can be proud of the fact that articles describing our work have appeared in the "Bulletins" of both the Maryland and National Medical Research Societies.

LEGISLATIVE LIGHTS

Did you know that there is a proposed 23rd Amendment to the Constitution—a bill which would limit government competition with private professions and businesses?

Also, there is a House joint resolution (No. 268) limiting income tax to not more than 25% of anyone's income! If you approve these measures, why not support them?

Did you know that women's organizations and women's magazines are propaganda targets for 1952? Let us weigh the truth of what we read and hear. Our loyalty should be to the U. S. principle of the rights of the individual, not to any party, administration, or government department.

Did you know that, in a survey of several hundred consecutive admissions to a Veteran's Hospital, 90% were admitted for illnesses which were not service connected? Sixty-five (65) per cent of the total number of patients admitted willingly took the "Pauper's Oath," in order to enter! How many of these could well afford to be treated at their own expense?

The sum of $10,000 was awarded to Senator James E. Murray, Democrat of Montana, by the C.I.O. This award was turned over to the "Committee for the Nation's Health," for use in promoting National Compulsory Health Insurance, in the U. S. A.

Colorado has the honor of *being the first* of the Woman's State Auxiliaries to contribute to the American Medical Education Foundation (the A.M.A.'s private fund for Medical Education).

AMERICANISM QUIZ

"How do we play into the hands of communists when we defend Americans in groups, according to color, minority or economic interests, rather than as individual citizens?"

For the answer read "The Key to Peace," by Clarence Manion. Heritage Foundation Inc., 75 East Wacker Drive, Chicago, Illinois. $2.00. The Public Libraries.

"Would you let your husband stop the practice of medicine and sacrifice your security, to run for Congress and work for better government? (You let them take your son for Korea!)" Excerpt from a speech at the Chicago Conference, made by Doctor Judd, Congressman from Minnesota, who did give up his medical practice to work for the U. S. A.

"Why have educators only themsleves to blame if the germ of cynical worldliness and moral delinquency has invaded the college campus?" Dr. Gibson in his inaugural address at Washington College, Chestertown, Maryland, gives the answer. His opinion that educators today are yielding to outside pressures and to the encroachment of the Federal Government is supported by Dr. Felix Worley, former President of Haverford College.

Ancillary News

PHARMACY SECTION

L. M. KANTNER, *Phar.D.*

Director Drug Control, State Department of Health and Secretary of the Maryland Board of Pharmacy

The Medical and Chirurgical Faculty is to be congratulated upon the inauguration of a monthly journal. I feel assured this journal will have enthusiastic support, and will prove a most valuable publication to the practicing physician. It is indeed a privilege to be afforded an opportunity to contribute to this, the first edition.

This would seem an appropriate time to briefly discuss the recently enacted amendment to the Federal Food, Drug, and Cosmetic Act, which affects the prescribing and dispensing of what may be termed "Dangerous Drugs."

In 1948, the Commissioner of the Food and Drug Administration, in an interpretation of the law, held that *any* prescription once filled could not be legally refilled, and compared a prescription once filled to a "canceled check."

This interpretation caused interested groups to protest such a ruling, with the final outcome of the presentation and passage by the Congress of an amendment to the Federal Food, Drug, and Cosmetic Act clarifying this controversial question.

The continuous development of new drugs, together with a better understanding of the pharmacological action of many of the older drugs, makes necessary legal restrictions to surround the administration and dispensing of these products. That is what this amendment has endeavored to do as well as to clarify a confused condition.

Drugs intended for use by man are now divided into two classes: namely, those that can only be dispensed on prescription, whose label must include: "Caution: Federal law prohibits dispensing without prescription."

Prescriptions for these drugs can be ordered on written prescriptions or given orally by the physician. In the latter case, the pharmacist must immediately reduce the order to writing and file. Such prescriptions cannot be refilled except by authorization of the physician, either on the original prescription or by oral instructions. Physicians' clerical or professional assistants may orally convey the physician's instructions to refill such prescriptions. However, the patient cannot orally transmit such instructions.

In the second class are drugs that can be sold without prescriptions. Prescriptions for this class of drugs can be refilled without the prescriber's authorization.

Physicians can save themselves a great deal of annoyance if they form the habit of indicating on their written prescriptions that they may or may not be refilled by using such abbreviations as N.R., Refill 1–2–3–4 times, or Refill P.R.N. When only the term "Refill" is used on prescriptions, it will most likely be held to refill once and once only.

This amendment should not be confused with the State Barbiturate Act, which provides that prescriptions for straight barbiturates, such as Nembutal, Seconal, Barbital, etc., must be written by the physician. The Maryland law does not provide for oral prescriptions for these drugs. However, physicians may authorize them to be refilled on the written prescription.

Letters to the Editor

November 1, 1951

Dr. George H. Yeager, Secretary
The Medical and Chirurgical Faculty
1211 Cathedral Street
Baltimore 1, Maryland

Dear Dr. Yeager:

I have conferred with Mrs. H. Hanford Hopkins, President of the Woman's Auxiliary to the Baltimore City Medical Society, and with our Program Chairman regarding preparation of our meeting notices to appear in the new Journal in January 1952.

The Woman's Auxiliary would like to congratulate the Society on the new undertaking and affirm our fullest cooperation.

Most sincerely,
Louise F. Johnson
(Mrs. Marius P. Johnson)
Corresponding Secretary
Woman's Auxiliary to the
Baltimore City Medical Society.

ANNUAL MEETING FEATURE

April 29 and 30, 1952

The Woman's Auxiliary to the Medical and Chirurgical Faculty will sponsor, under the Chairmanship of Mrs. Beverley C. Compton, a Creative Arts Show. In 1951 this was an outstanding event of the Annual Meeting. The members, their wives and children, are urged to exhibit. Send your requests to enter the 1952 Show to Mrs. Compton at the Faculty Building, 1211 Cathedral Street.